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

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

Original Public Report

Report Issue Date August 18, 2022
Inspection Number 2022_1204_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Schlegel Villages Inc.

Long-Term Care Home and City
Hamilton Continuing Care, Hamilton

Lead Inspector
Daniela Lupu (758)

Additional Inspector(s)

Inspector Digital Signature
Daniela Lupu
Digitally signed by Daniela Lupu
Date: 2022.08.22 16:05:11 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 4-5, and 8-10, 2022.

The following intake(s) were inspected:

- Log # 018139-21 (Complaint), related to abuse and neglect and staff qualifications.

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

- Continence Care
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Safe and Secure Home
- Skin and Wound Prevention and Management
- Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC#001 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 a resident's plan of care for skin and wound and continence care was complied with.

Rationale and Summary

A. A resident was at risk for skin breakdown and needed to be turned and repositioned by two staff members at specified time intervals and this was to be documented.

An agency staff member attempted to turn the resident by themselves, but they were unable to turn and reposition the resident.

The resident was found with a new area of skin injury the next shift. There was no documentation of the turning and repositioning task from the previous shift.

The Director of Nursing Care (DNC) acknowledged that the care was not provided as specified in the resident's plan of care for turning and repositioning.

Not providing the care as indicated in the plan of care had a moderate impact on the resident as it may have contributed to the resident's injury and put the resident at risk associated with immobility and skin breakdown.

Sources: a resident's clinical records, the home's investigative notes, interviews with three PSW and with the DNC.

B. A resident needed to wear a continence product related to their medical condition. The resident needed assistance from two staff members to complete their continence care at certain times and this was to be documented.

An agency staff member attempted to provide continence care to the resident by themselves, but they were unable to change their continence product.

The resident was found with a soiled continence product the following shift. There was no documentation of the continence care task from the previous shift.

The DNC said the agency staff member was not familiar with the application of the continence product and with the home's specific continence products. They also said the continence care should have been provided as specified in the plan of care and documented on the resident's clinical records.

Not providing the resident with continence care as indicated in their plan of care put the resident at moderate risk for skin impairment.

Sources: a resident's clinical records, the home's investigative notes, interviews with two PSW and the DNC.
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WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 24 (1) 2

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary

The home received a complaint alleging abuse and neglect of a resident.

An investigation of the suspected abuse and neglect was completed, but the incident was not reported to the Director.

The DNC acknowledged that the suspicion of abuse and neglect was not reported to the Director as required.

The home's failure to report to the Director immediately the suspicion of abuse and neglect of a resident, may have delayed the Director's ability to respond to the incident in a timely manner.

Sources: a resident's clinical records, the home's complaint record and investigative notes, and interviews with the DNC and other staff.

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WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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

The licensee has failed to ensure that the home's policy to promote zero tolerance for abuse and neglect was complied with.

Rationale and Summary

A complaint was received by the home alleging abuse and neglect of a resident by a staff member.

The home's prevention of abuse and neglect policy, documented that the home should follow a specific investigation process for suspected abuse of a resident by a team member, volunteer or visitor. The investigation procedure documented that the accused team member, witnesses including other team members should be interviewed. In all cases of actual/suspected physical abuse where an injury was sustained, the physician should be notified, and a detailed description of the incident was to be documented in the resident's record.

The home's investigative records of a resident's alleged abuse, as well as interview with the DNC established that there were no interviews with the accused staff member or any team members who worked during the time the alleged abuse occurred. There was no documentation that the physician was informed of the resident's physical injury. Additionally, the resident's records did not contain a description of the incident.

By not following the home's investigation process for suspected abuse of a resident by a team member, the circumstances and the cause of the incident could not be accurately determined and interventions to mitigate the risk of reoccurrence could not be identified.

Sources: a resident's clinical records, the home's complaint record and investigative notes, the home's prevention of abuse and neglect policy, and interviews with the DNC, Administrator and former Administrator.

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WRITTEN NOTIFICATION: STAFF QUALIFICATIONS

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 73 (a)

The licensee has failed to ensure that an agency staff member who was assigned to provide resident care as a personal support worker, had the skills and qualifications to perform their duties.

Rationale and Summary

A complaint was received by the Ministry of Long-Term Care (MLTC) alleging abuse and improper care of a resident by an agency staff member who did not have the qualifications of a Personal Support Worker.

An agency staff member was assigned to perform Personal Support Worker duties for the residents on one of the resident home areas. They attempted to provide care to a resident by

themselves, but they were unable to complete the resident's care. The following shift, the resident was found with their continence product soiled and with a skin injury.

The agency staff member was not familiar with the techniques for turning and repositioning residents and applying their continence products. They did not receive support to provide care to the resident as indicated in their plan of care.

The home's DNC and the former Administrator said that the agency staff member did not have the qualifications of a Personal Support Worker. They also said a training session related to continence care was provided after the incident.

The home's current Administrator could not locate any records to indicate that the agency staff member received education or training prior to being assigned to perform PSW duties, or any documentation of the agency staff's qualifications.

Failing to ensure that a staff member had the skills and qualifications to perform the Personal Support Worker duties had a moderate impact on a resident as it resulted in the resident missing care, may have contributed to their injury, and put them at risk for harm.

Sources: a resident's clinical records, the home's complaint record and investigative notes, and interviews with the DNC, former Administrator and other staff.

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WRITTEN NOTIFICATION: AIR TEMPERATURE

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 24 (3)

The licensee has failed to ensure that the temperatures were measured and recorded once every evening or night in three cooling areas and two resident bedrooms in different areas of the home.

Rationale and Summary

The home's air temperature logs showed that the temperatures in the home's three cooling areas and two resident bedrooms were not recorded in the evening or night on a specific time period.

The home's Maintenance/ Environmental Lead acknowledged that the temperatures were not monitored every evening or night as required.

By not monitoring and recording the temperatures in all cooling areas and two resident bedrooms once in the evening or night, there was a potential risk that interventions could not be implemented in a timely manner if the temperatures were outside of the expected range.

Sources: the home's air temperature logs, and an interview with the home's Maintenance/Environmental Lead.

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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC#006 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 was required to implement any standard or protocol issued by the Director with respect to IPAC.

A. 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 residents will be offered and encouraged to perform hand hygiene around meals and snack times.

On one occasion, during a lunch meal service, two PSW did not encourage or assist four residents with hand hygiene before they received their meal.

A PSW, a RN and the home's DNC/IPAC Lead said that residents should be encouraged with hand hygiene before and after their meals.

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

Sources: observation of a lunch meal service, the home's hand hygiene policy, IPAC Standard (April 2022), and interviews with the home's DNC/IPAC Lead and other staff.

B. The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section

9.1 indicates that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. Routine Practices should include the four moments of hand hygiene, environmental controls including cleaning procedures and proper use of Personal Protective Equipment (PPE), such as appropriate selection, application, removal, and disposal.

i) The home's hand hygiene policy, documented that staff should follow the four moments of hand hygiene, including performing hand hygiene before contact with the resident or their environment, after body fluid exposure risk, and after resident or environment contact.

On one occasion, during a lunch meal service, a PSW did not perform hand hygiene before and after contact with three residents and their environment while assisting these residents with their meal. Additionally, the same PSW did not perform hand hygiene after body fluid exposure and before leaving the dining room area and touching a different resident's food tray.

On a separate occasion, during a lunch meal service, a PSW did not perform hand hygiene after exposure to body fluid and before contact with two residents and their environment. Additionally, the PSW did not perform hand hygiene before they left the dining room area.

The home's DNC/IPAC Lead and Environmental Lead/Neighbourhood Coordinator said staff should have performed hand hygiene before and after contact with the residents and their environment, and after body fluid exposure.

Sources: observations of lunch meal service on two home areas, the home's hand hygiene policy, IPAC Standard (April 2022), and interviews with the DNC/IPAC Lead, Environmental Lead/ Neighbourhood Coordinator and other staff.

ii) The home's contact precautions policy, documented that the resident shared equipment should be disinfected after each use with hospital-grade disinfectant.

A resident was on contact precautions due to their medical condition. On one occasion a RN did not disinfect the shared equipment after they used it for the resident.

The home's DNC/IPAC Lead said that shared equipment should be disinfected after each use before leaving the resident's room.

Sources: observation of a resident on contact precautions, the home's contact precautions policy, IPAC Standard (April 2022) and an interview with the DNC/IPAC Lead and the Environmental Lead/Neighbourhood Coordinator.

iii) The home's cleaning principles policy documented that staff should change cloths used for cleaning the resident bed space area for each resident and remove their gloves before leaving the resident's room followed by completing hand hygiene.

On one occasion, a housekeeping staff used the same cloth to clean the bed space area of two residents. Additionally, they exited the residents' room without removing their gloves and

did not perform hand hygiene after they removed their gloves and donned a new pair of gloves.

The home's Environmental Lead/Neighbourhood Coordinator said staff should have changed the cloth before cleaning a different resident bed space area in the same room. They also said gloves should be removed before exiting the resident's room and hand hygiene performed after removing gloves.

Sources: observation of cleaning and disinfecting of high touch areas, the home's cleaning principles policy, IPAC Standard (April 2022) and interviews with the home's Environmental Lead /Neighbourhood Coordinator.

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