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

Toronto District
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Original Public Report

Report Issue Date: June 8, 2023

Inspection Number: 2023-1345-0003

Inspection Type:
Complaint
Critical Incident System

Licensee: Labdara Foundation

Long Term Care Home and City: Labdara Lithuanian Nursing Home, Etobicoke

Lead Inspector	**Inspector Digital Signature**
April Chan (704759)	April W Chan Digitally signed by April W Chan Date: 2023.06.13 13:32:00 -04'00'

Additional Inspector(s)
Kim Lee (741072)
Chinonye Nwankpa (000715)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 2 - 5, 8 - 11, 2023.
The inspection occurred offsite on the following date: May 12, 2023.

The following intake(s) were inspected:

- Intake: #00005396 – Critical Incident (CI) related to suspected resident to resident abuse
- Intake: #00020198 - CI related to falls prevention
- Intake: #00021173 - CI related to falls prevention
- Intake: #00021207 - CI related to falls prevention
- Intake: #00084667 - Complaint related to alleged staff to resident abuse, dining, training, care concern, falls prevention
- Intake: #00084668 - Complaint related to alleged staff to resident abuse

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that a policy directive that applied to the Long-Term Care Home (LTCH), the Minister's Directive: COVID-19 response measures for LTCHs, was complied with.

In accordance with the Directive, licensees were required to ensure that Alcohol-Based Hand Rub (ABHR) products used were not expired as set out in the document, "Selection and Placement of ABHR during COVID-19 in Long-term Care and Retirement Homes".

Rationale and Summary
On May 2, 2023, at a resident home area, the hand sanitizer products being used by staff and for resident hand hygiene during a lunch meal had expired. The inspector gave the expired hand sanitizers to registered nurse (RN), who agreed that the bottles had expired and would be discarded and replaced. However, the hand sanitizer bottles were left on the unit and it was later observed being used by another staff to wash a resident's hand after the lunch meal. Two days later, the Infection Prevention and control (IPAC) lead confirmed that an audit was done in the entire home and all the expired hand sanitizers had been removed from the units. The IPAC

lead acknowledged the risk of using expired hand sanitizers included reduced efficacy and risk of spreading infections.

There was a risk of decreased effectiveness in prevention of spread of infectious diseases if an expired ABHR product was used.

Sources: Dining observations on May 2, 2023, interviews with an RN and IPAC lead. [000715]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

(i) The licensee has failed to ensure that all staff participated in the implementation of their Infection Prevention and Control (IPAC) program, specifically when a staff member did not wear a medical mask properly while interacting with a resident.

Rationale and Summary
On May 10, 2023, a staff member was observed in an office having a conversation with a resident in close proximity. The staff member had their mask below their nose, upon seeing the inspector, they immediately adjusted their mask to cover their nose. Some minutes after, they were also observed pulling their mask away from their face repeatedly while talking to the same resident. The home's Universal Mask and Eye Protection During Covid-19 policy states that all staff must wear a medical mask for the entire duration of their shift (indoors and outdoors), and that masks must not be removed while interacting with residents. An interview with the staff member verified that they did not wear their mask properly while communicating with the resident.

IPAC lead verified that masking was mandatory for everyone and that masks should cover nose and mouth. The IPAC lead noted that masking compliance was an area of improvement, evidenced by their IPAC results and they plan to continue providing education to address this

matter. The IPAC lead acknowledged that there was potential risk for spreading infection when staff are not wearing their mask properly.

When a staff member failed to properly wear medical mask indoors while interacting with a resident, there was risk of infection transmission.

Sources: Observations on May 10, 2023, the home's Universal Mask and Eye Protection During Covid-19 policy, interviews with the staff member and IPAC lead. [000715]

(ii) The licensee failed to ensure that a staff member participated in the implementation of the IPAC program related to indoor masking procedures.

The home's policy entitled Universal Mask and Eye Protection During Covid-19 required staff members must wear a medical mask for the duration of their shift and that masks must not be removed while interacting with residents.

Rationale and Summary
On May 3, 2023, the staff member was observed during an activity in front of a room with residents. The staff member was not wearing a medical mask during the indoor group activity with the residents.

The staff member indicated that they were not wearing a medical mask during the resident group activity and that they should have had the medical mask on.

The Administrator indicated that the home’s masking policy was to keep masked while indoors. They indicated that the home provided discussion with the staff member to maintain indoor masking requirements.

There was risk identified when a staff member was not wearing a medical mask indoors while performing an activity in front of a room of residents.

Sources: observations on May 3, 2023, the home's policy entitled Universal Mask and Eye Protection During Covid-19 policy, interviews with the staff member and Administrator. [704759]

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)

The licensee has failed to ensure that resident #002 was protected from physical abuse by resident #003.

Section 2 of the Ontario Regulation 79/10 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain, administering or withholding a drug for an inappropriate purpose, or the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary
A Critical Incident (CI) report was received by the Ministry of Long-Term Care (MLTC) that detailed an incident, where resident #003 had a physical interaction with resident #002 and caused a fall. Resident #002 sustained an injury resulting from the fall.

A personal support worker (PSW) stated that they discovered resident #002 on the floor on a specific date. The PSW reviewed evidence that showed resident #003 having a physical interaction with resident #002, causing them to fall to the floor. It was later determined that resident #002 sustained an injury caused by the fall. The PSW stated that they did not know if resident #003's actions against resident #002 met the definition of physical abuse.

An Assistant Director of Care (ADOC) stated they did not consider the incident physical abuse because both residents had cognitive impairments.

The Director of Care (DOC) stated that they believed that resident #003's actions that caused resident #002 to fall, was not abuse. The DOC stated that resident #003 did not have intention to harm resident #002 and could not appreciate the consequences of their actions. The DOC stated that the LTCH interpreted the definition of physical abuse to include the provision that intention to harm must be present. As the LTCH did not consider physical abuse, the LTCH did not enact steps outlined in the LTCH’s abuse and neglect prevention program.

The Ontario Regulation 79/10 definition of "physical abuse" includes "the use of physical force by a resident that causes physical injury to another resident," and does not outline any stipulation about an individual's cognition level or intent.

At the time of the incident, the LTCH's abuse and neglect prevention program's definition of "physical abuse" included "the use of physical force by a resident that causes physical injury to another resident." The incident was not recognized by the PSW, the ADOC, and DOC as an incident of abuse of resident #002 by another resident.

The LTCH failed to protect resident #002 from abuse. Additionally, in failing to recognize resident #003 actions against resident #002 as physical abuse, the LTCH did not take appropriate action following the incident of abuse putting residents at risk for incidents of unrecognized abuse.

Sources: Interviews with staff, LTCH's Abuse and Neglect Prevention Program document, Ontario Regulation 79/10 [741072]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that a planned routine for a resident was followed as specified in the plan of care.

Rationale and Summary
A CI report was submitted to the Director related to the resident's fall with injury.

The resident was identified at risk for falling. The home's Falls Prevention Program policy noted that residents at risk for falls would have a specific planned routine implemented, and the PSWs were responsible to follow the care plan fall interventions. The resident's care plan stated a planned routine was to be implemented at specified times and as needed as part of their falls prevention intervention.

On a specific date, the resident did not received planned care at a specified time. The planned care at the specified time was also not documented. An interview with a PSW verified that they did not implement the planned care at the specified time for the resident as stated in the care plan prior to the fall. The DOC acknowledged that planned care was not provided to the resident as per care plan.

There was risk identified when the staff failed to implement planned care for the resident as indicated in the care plan.

Sources: Critical Incident Report, Falls Prevention Program policy, the resident's care plan, the resident's progress notes, clinical records; Interview with the DOC, a PSW and other staff. [000715]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

(i) The licensee failed to implement measures in accordance with the Infection Prevention and Control Standard for Long Term Care Homes April 2022 (IPAC Standard).

Specifically, the licensee failed to ensure their staff completed hand hygiene, at a minimum the four moments of hand hygiene as required by Additional Requirement 9.1 (b) under the IPAC Standard.

Rationale and Summary
On May 2, 2023 at lunch time, a volunteer was observed assisting a resident in the dining room at their table. Shortly after, the volunteer was assigned to assist another resident with their meal at another table. No hand hygiene was observed when they moved from one resident to the next. After the volunteer finished assisting the second resident with their meal, they exited

the dining room area without washing their hands. The home's Volunteer Handbook instructs volunteers to wash their hands upon entry into the premises, before starting their task, between helping different residents, before handling food, before setting up equipment and when they exit the premises. During the volunteer's interview, they confirmed that they had not washed their hands between assisting the two residents and after meal assistance. They could not recall if the home had provided them with any hand hygiene or infection prevention and control training.

A PSW was observed in the servery area without performing hand hygiene before preparing a tray for a resident on May 2, 2023. They proceeded to the resident's room to deliver the tray, and came out without washing their hands. In addition, the home's Hand Hygiene Requirement's policy indicated hand hygiene should performed including but not limited to the four moments of hand hygiene (before initial resident or resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident or resident environment contact); before preparing, handling, serving or eating food; after touching any areas of a resident and; before entering or exiting a resident's room. The PSW acknowledged that they did not wash their hands before going into the resident's room. They also noted that they could have dropped it on the table in the resident's room and washed their hands afterwards.

The IPAC lead acknowledged that staff and volunteers were expected to wash their hands between assisting residents, when handling the tray, as well as after coming out of the resident’s room. They also verified that volunteers received infection control orientation by reviewing the Volunteer Handbook, but they could not verify if the volunteer had received such training.

When the volunteer and staff failed to wash their hands before and after resident or resident environment contact, they increased the risk of infection transmission.

Sources: Dining observations on May 2, 2023, the home's Volunteer Handbook, the home’s Hand Hygiene Requirement policy, interviews with a PSW, a volunteer and IPAC lead. [000715]

(ii) The licensee failed to implement measures in accordance with a standard issued by the Director with respect to infection prevention and control.

Specifically, the licensee did not ensure that the hand hygiene program implemented on February 18, 2023, included policies that support for residents to perform hand hygiene prior to receiving meals and snacks as required by Additional Requirement 10.4 (h) under the IPAC Standard.

Rationale and Summary
On May 9, 2023, a PSW was observed offering snacks and assisting residents with eating. The PSW was not observed supporting several residents to perform hand hygiene prior to receiving snacks.

The PSW indicated that they did not offer hand hygiene for the residents prior to snack service because hand hygiene was not required for that resident home area.

The IPAC lead, and other direct care staff members indicated that there was an expectation for residents on the floor to receive support for hand hygiene during snack service. Hand sanitizer was expected to be offered to residents for performing hand hygiene.

The home's hand hygiene policy did not indicate support for residents to perform hand hygiene prior to receiving meals and snacks.

The IPAC lead acknowledged that the home's hand hygiene policy did not clarify support for residents to perform hand hygiene prior to receiving meals and snacks as specified in the IPAC Standard. They indicated that they would bring this concern to review with their IPAC manager and would stock hand sanitizer on the snack carts.

Sources: the home's policy on Hand Hygiene Requirements, observations on May 9, 2023, interviews with staff members and the IPAC lead. [704759]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)

The licensee has failed to ensure that a documented record was kept in the home of a complaint from a resident's family member that included; the action taken to resolve the complaint, the final resolution, any response provided to the complainant, and the complainants response.

Rationale and Summary
The home's Complaint Procedure policy stated complaints were to be documented in the complaint investigation report, and for a record to be kept of the nature of the complaint, date it was received, the action taken to resolve the complaint, the final resolution, and every date of any response that was provided to or received from the complainant. On a number of occasions, the resident's family member reported a service concern as documented in the resident's clinical notes. A review of the complaint log revealed there were no entries or complaint reports for the service concern.

A registered practical nurse (RPN) acknowledged they received the verbal complaint from the resident's family member and documented it in the progress notes, however stated they might have missed completing the complaint record or the maintenance requisition log. An interview with Environmental Services Manager (ESM) verified that he was not made aware of the complaint from the staff, rather that the family member had eventually gone to him directly about their concern, but they could not recall the date. The ESM stated that the same day they received the complaint, they took the appropriate measures to address the issue. Subsequently, the ESM stated they reported their action and the resolution to the complainant.

The ESM also confirmed that there was no documentation of the date they received the complaint, nature of the concern, the action they took, the resolution, the response to the complainant and the complainants response. The Administrator acknowledged they were unaware of the complaint as it was not found in their complaint log, that the home failed to document the complaint as required in their policy.

When the home failed to keep a record of the complaint, it may affect the home's ability to track, review and analyze their complaints for making improvements.

Sources: The home's Complaint Procedure Policy, the resident's progress notes, the home's complaint log, interview with an RPN, ESM and Administrator. [000715]