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

Hamilton District
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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: January 10, 2023	
Inspection Number: 2022-1087-0001	
Inspection Type: Follow up Critical Incident System	
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP	
Long Term Care Home and City: Fox Ridge Care Community, Brantford	
Lead Inspector Nishy Francis (740873)	**Inspector Digital Signature** Nishy Francis Digitally signed by Nishy Francis Date: 2023.01.13 12:33:30 -05'00'
Additional Inspector(s)	

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
O. Reg. 79/10	s. 229 (4)	2022_956723_0004	#001	Nishy Francis (740873)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 13 - 21, 2022

The following intake(s) were inspected:
- Intake #00006453 (follow up) related to infection prevention and control
- Intake #00012216 (CIS # 2570-000037-22) related to medication management.

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

Infection Prevention and Control
Medication Management

INSPECTION RESULTS

Non-Compliance Remedied

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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, was implemented.

Rationale and Summary

The IPAC Standard for Long-Term Care Homes, stated under section 9.1 that Additional Precautions shall include (e) point-of-care signage indicating that enhanced IPAC control measures were in place.

A resident's clinical record indicated they required additional precautions. The resident resided in a shared room and signage indicating additional precautions was posted outside the room. Staff were unable to distinguish which resident in the shared room required additional precautions by looking at signage posted outside the room.

As per the document titled Routine Practices and Additional Precautions in All Health Care Settings, signage that lists the required precautions should be posted at the entrance to the resident's room or bed space.

This was communicated to Director of Care (DOC) and signage was placed inside the shared room at the resident bed space. This non-compliance was identified as having low risk to the resident and was remedied during the inspection.

Sources: Observations; Interviews with staff and DOC; Review of resident's clinical record, Routine Practices and Additional Precautions in All Health Care Settings 3rd edition, November 2012.

Date Remedy Implemented: December 20, 2022 [740873]

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 3 (1)(18)

The licensee has failed to ensure privacy in treatment for a resident.

Rationale and Summary:
A resident's clinical record stated they required additional precautions. Signage posted outside the resident's door indicated additional precautions and information regarding their health condition.

The home's Identification of Isolation Rooms policy, stated to post signage that did not indicate personal health information.

As per the document titled Routine Practices and Additional Precautions in All Health Care Settings, signage should maintain privacy by indicating only the precautions that are required, without information regarding the resident's condition.

This was communicated to the DOC who removed the signage which indicated the resident's health condition. This non-compliance was identified as having low risk to the resident and was remedied during the inspection.

Sources: Observations; Interview with DOC; Review of resident's clinical record, home's policy titled Identification of Isolation Rooms revised April 2022, Routine Practices and Additional Precautions in All Health Care Settings 3rd edition, November 2012.

Date Remedy Implemented: December 20, 2022 [740873]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM
NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that staff participated in the implementation of the Infection Prevention and Control (IPAC) program specifically related to performing resident hand hygiene.

Rationale and Summary:
The home's Hand Hygiene policy stated that personal support workers/resident care aide and recreation/program team will wash residents' hands before and after eating.

Staff were observed to provide snacks and drinks during the afternoon snack service without supporting or assisting residents with hand hygiene prior to receiving snacks. Staff confirmed they were aware of the Hand Hygiene policy and had completed training on the same.

When staff failed to encourage or assist residents with performing hand hygiene prior to consuming snacks and drinks, there was a risk of the residents contracting or transmitting infections.

Sources: Observations; Interview with staff; home's policy titled Hand Hygiene #IX-G-10.10 revised December 2021. [740873]

WRITTEN NOTIFICATION: LICENSEE MUST COMPLY
NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 101 (4)

Compliance Order (CO) #001 from Inspection Report #2022_956723_0004 for Ontario Regulation (O. Reg.) 79/10 s. 229 (4) with compliance due date April 29, 2022, was not complied with.

Rationale and Summary:

A. The licensee failed to perform an audit to ensure all residents were encouraged to or assisted with performing hand hygiene for a period of three months or until such time as hand hygiene is consistently being encouraged and or/performed, as required by the CO. The Assistant DOC confirmed the hand hygiene audits did not include all residents.

B. The licensee failed to ensure that the audit identified the person who completed the audit and any actions taken, as required by the CO. The DOC and clinical consultant could not determine who was audited and whether corrective action and a subsequent audit was completed to ensure the staff member followed the Hand Hygiene protocol.

Sources: CO #001 from Inspection Report #2022_956723_0004, Hand hygiene audits, Interviews with the assistant DOC, DOC, and Clinical Consultant. [740873]

COMPLIANCE ORDER [CO #001] DIRECTIVES BY MINISTER
NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with s. 184 (3) of the FLTCA.

The licensee shall:

1. Ensure every registered staff pursuant to a contract or agreement between the licensee and an employment agency or other third party are provided an updated orientation

checklist, prior to commencing their shift, that includes the Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia.
2. The home must keep a written record that identifies registered staff by name, the date they received/reviewed updated orientation checklist prior to commencing their shift, and signatures of the registered staff post review of the checklist.
3. The home must conduct an audit of every incident of severe hypoglycemia or unresponsive hypoglycemia for a period of one month to ensure every incident involving a resident is:
    a. Reviewed and analyzed, and documented as per the home's policy,
    b. Reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.
4. The home must keep written record of the audit, identify the person who completed the audit, the date of the audit, and any actions taken if required.

Grounds

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with.

Rationale and Summary:
A) Specifically, as per the Directive, a registered staff failed to report to required personnel when a resident experienced a medical incident. The DOC confirmed this medical incident was not reported to the required personnel.

The Home's policy, stated to notify the Medical Director, attending physician or Nurse Practitioner, DOC, resident and/or substitute decision maker of every medical incident.

When the registered staff did not communicate the incident to the required personnel, there was significant risk to the resident's health and safety.

B) Specifically, as per the Directive, a registered staff failed to ensure that when a resident experienced a medical incident, the incident was analyzed and reviewed.

The DOC stated every medical incident must be documented in a medication incident report which included review and analysis, by the staff providing care at the time. The DOC confirmed this was not completed when a resident experienced a medical incident.

The Home's policy stated that a medication incident report was to be completed for every incident of this type.

When the registered staff did not complete a review and analysis, this did not allow for review of trends, and analysis of changes in the resident's health condition which has the potential for risk of harm to occur to the resident's health.

Sources: Interview with registered staff, and DOC; Review of resident's clinical record, Home's policy revised June 2020, Agency staff orientation checklist. [740873]

This order must be complied with by: February 21, 2023.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

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

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

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

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

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

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

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

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

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

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

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

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