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

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Original Public Report

Report Issue Date: February 9, 2023	
Inspection Number: 2023-1363-0002	
Inspection Type: Critical Incident System	
Licensee: Steeves & Rozema Enterprises Limited	
Long Term Care Home and City: Westmount Gardens Long Term Care Home, London	
Lead Inspector Christie Birch (740898)	**Inspector Digital Signature** Christie Birch Digitally signed by Christie Birch Date: 2023.02.09 16:13:34 -05'00'
Additional Inspector(s) Andrea Dickinson (740895)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): January 18, 19, 23, 26, 27, 2023.
The following intake(s) were inspected:

- Intake: #00002117-CI: 2878-000030-22 Fall of resident resulting in injury.
- Intake: #00012058-IL-06683-AH/CI:2878-000040-22 Fall of resident resulting in injury.

Inspection Manager Amie Gibbs-Ward was also present during this inspection.

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

Falls Prevention and Management
Infection Prevention and Control

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)
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.

The licensee failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, when they did not ensure that their disinfectant products were not expired prior to using them.

The Minister's Directive: COVID-19 response measures for long-term care homes, section 1.4 Environmental cleaning references the Provincial Infectious Diseases Advisory Committee on Infection Prevention and Control's (PIDAC-IPC) Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition, April 2018, which states "there should be systems in place to ensure the efficacy of the disinfectant over time (e.g. review of expiry date)."

During an observation a container of "Preempt" disinfectant wipes with an expiration date of August 2022, was observed on the nursing desk. Two containers of "Preempt" disinfectant wipes were observed on two separate mechanical lifts, both with an expiration date of August 2022, and a container of "CaviWipes" disinfectant wipes was observed on a mechanical lift with an expiration date of January 2022.

During an interview the Manager of Resident Care (MRC) confirmed that the disinfectant products were expired.

During another observation, two of the four expired disinfectant wipe products had been removed from the neighbourhood. After the neighbourhood Registered Practical Nurse (RPN) was notified of the remaining two expired products, the products were disposed of and replaced.

Sources: Observations; Interview with MRC.

Date Remedy Implemented: January 19, 2023

[740895]

WRITTEN NOTIFICATION: Plan of Care Documentation

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

Non-compliance with FLTCA 2021, s. 6 (9) 1
The licensee failed to ensure that the provisions of the care set out in the plan of care were documented for resident's care.

Rationale and Summary

An order for a treatment was written for a resident. In a review of Point Click Care (PCC) medication record, treatment record and care plan, there was no documentation of the treatment orders, administration, or effects of the treatment.
In a review of the home's policy, it was found that the order was to be transcribed into PCC in progress notes, the care plan, and the electronic treatment record.

In an interview with the MRC, they stated that the order was not transcribed and signed off as expected, into the medication or treatment record in PCC. They indicated that the expectation would be for staff to follow the policy and document in the care plan, the treatment record and progress notes in PCC and this was not done.

The lack of documentation of the provision of care placed this resident at risk for not receiving their care in accordance with the order.

Sources: Point Click Care resident file; care plan, progress notes; physician orders; interview with MRC; Clinical Procedure Policy Number 13-36 dated June 27, 2013.

[740898]

WRITTEN NOTIFICATION: Staff Retraining-IPAC

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

Non-compliance with FLTCA s. 82 (4).
The licensee has failed to ensure that staff receive retraining in infection prevention and control (IPAC) at times or at intervals provided for in the regulations.

In accordance with O. Reg. 260. (1), the intervals for the purposes of subsection 82 (4) of the Act are annual intervals.

Specifically, all staff did not receive the required annual training in IPAC for the year 2022.

Rationale and Summary
Review of the home's Surge Learning Report, specifically the Infection Prevention and Control Series, showed 49.1% staff completion with no evidence of the specific attendees.

During an interview with the IPAC lead, they stated that the majority of staff received IPAC education in 2022. They also stated that this would pose a risk to resident care.

During another interview with the IPAC lead, they stated that they reviewed all sources of IPAC staff education and 49% received their in-person training and 80% received the online Surge training in IPAC. The IPAC lead could not clarify the contents of the online Surge education or that all staff received the required pieces of education.

There was risk at the time of inspection to resident safety as lack of training could lead to increased infections and transmissions.

Sources: Surge Learning Report 2022; IPAC agenda in-person training; Interviews with IPAC lead

[740898]

WRITTEN NOTIFICATION: Falls Prevention and Management

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

Non-compliance with: O. Reg. 246/22 54. (1)

The licensee failed to ensure that when a resident fell, the Head Injury Routine (HIR) protocol was completed for 72 full hours after the resident's re-admission to the home from the hospital.

In accordance with O. Reg. 246/22 s. 11 (1) (b) the licensee is required to ensure the home's falls prevention and management program was in place, and ensure it was complied with.

Specifically, staff did not comply with the licensee's Head Injury Protocol which was part of the licensee's policy: Fall Prevention and Management Program Policy - Procedure 8 which stated A head injury protocol will be followed when a resident receives and injury to the head, a suspected injury to the head or an unwitnessed fall.

Rationale and Summary
The Critical Incident System (CIS) report submitted to the Director for the fall of the resident, stated that the resident had an unwitnessed fall. According to the CIS, the Registered Nurse (RN) assessed resident, vital signs stable, resident put in comfortable position, head injury routine initiated, Power of Attorney (POA) notified and agreed to send the resident to the hospital due to pain.

During a review of the resident's chart, a HIR document for their fall showed one set of neurological vital signs was documented before sending resident to hospital.

In a review of progress notes it was noted that resident returned from hospital the following day and no further evidence of neurological vital signs being completed.

Procedure eight, under the Fall Prevention and Management Program Policy, RCM 10-02-01, dated May 18, 2022, stated "A head injury protocol will be followed when a resident receives an injury to the head, a suspected injury to the head or an unwitnessed fall."

Head Injury Protocol Policy RCM 10-02-02, dated May 18, 2022, stated "The head injury protocol will be followed when a resident receives an injury to the head or a suspected injury to the head."

"3. A Registered Team Member will initiate the head injury protocol and assess if further medical intervention is required."

"6. A progress note will summarize the information collected from the head injury form on each shift for 72 hours."

Specifically, the HIR document indicated that blood pressure, pulse, pupils, and level of consciousness would be monitored on days and evenings on day two and three post head injury.

MRC/Falls Lead, acknowledged that the HIR was required for this resident's fall and that a HIR should have been completed for seventy-two hours and it was not completed as expected.

There was increased risk that this resident, who had an unwitnessed fall, may have had worsening or new neurological issues that went unnoticed after return from hospital.

Sources: Progress notes and paper chart; Fall Prevention and Management Program RCM 10-02-02 (Revised May 18, 2022); Head Injury Protocol Policy RCM 10-02-02, (dated May 18, 2022); interviews with MRC/Falls Lead

[740898]

WRITTEN NOTIFICATION: Plan of Care

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

Non-compliance with: FLTCA, 2021 s. 6 (10) (b)

A) The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

Rationale and Summary
Critical Incident System (CI) report was received by the Director related to the resident's fall with injury.

During an initial observation of the resident in their wheelchair, there were specific directions noted in the care plan for the resident's safety that were not being followed.

A review of the Resident Plan of Care Policy RCM 08-04 indicated that resident care plan will be reviewed and revised, as necessary, by the multidisciplinary team at the Post Admission Conference, at least quarterly and whenever there is a change in the resident's health status, needs or abilities.

During an interview with a Personal Support Worker (PSW), they indicated that the resident did not require the interventions in the care plan.

During an interview with the MRC/Falls Lead, they confirmed the care for this resident had changed and the care plan should have been updated and it was not.

There was low risk to the resident at the time of inspection as the resident received the care they required based on assessment.

Sources: Interviews with MRC/Falls Lead and PSW; Observations of resident; Record review of care plan and Policy -RCM 08-04 titled "Resident Plan of Care" last revised August 5, 2022.

[740898]

B) The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Rationale and Summary
During an observation a resident was observed using a mobility device. During a review of the Fall Risk Screening (Scott) assessment for this resident, the RPN completing the assessment had selected that a resident specific routine would be added to the care plan and specific safety interventions would be implemented. A review of the resident's plan of care, showed those interventions and directions missing for the current care of this resident.

During an observation of the resident's room, the intervention was missing as well. Staff confirmed the missing interventions.

Number five under the procedure section of the home's policy RCM 08-04 titled "Resident Plan of Care" last revised August 5, 2022, stated the resident care plan "will be reviewed and revised, as necessary, by the multidisciplinary team at the Post Admission Conference, at least quarterly and whenever there is a change in the Resident's health status, needs or abilities."

During an interview, the MRC/Falls Lead confirmed the expectation was that the resident's plan of care be updated with the interventions when the Fall Risk Screening (Scott) assessment identified the need for it after their fall.

There was low risk to the resident at the time of inspection as the resident received the care they required based on assessment.

Sources: Observations; Interviews with; policy RCM 08-04 titled “Resident Plan of Care” last revised August 5, 2022; Resident 's chart.

[740895]

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
A) The licensee has failed to ensure that they have implemented any standard or protocol issued by the Director with respect to infection prevention and control.

Specifically, the Minister’s Directive: COVID-19 response measures for long-term care homes states that licensees are required to ensure that the Covid 19 screening requirements as set out in the Covid 19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, are followed.

In reference to the COVID 19 Guidance Document for Long-Term Care Homes in Ontario, homes must ensure that all residents are assessed at least once daily for signs and symptoms of COVID-19, including temperature checks.

Rationale and Summary
Signage for droplet contact precautions was observed on the door of a resident shared room.

On review of the Resident Screening tool for COVID symptoms for both residents sharing that room, it was noted that the temperature was not completed when screening was completed on two days and another day no screening was completed.

In an interview with the IPAC lead they confirmed that the expectation was that every resident is monitored daily for COVID symptoms including temperature check and recorded in PCC in the Resident Screening tool for COVID symptoms, as well as they were to sign it if off on the electronic treatment record.

The IPAC lead also confirmed that this resident did not have a temperature documented on a certain day. They also confirmed that the other resident was not screened on another date and did not have a current temperature documented on two other dates. The IPAC lead also

confirmed that they completed audits on the Resident Screening Tool for COVID symptoms weekly but did not review the content of the tool, so they were unaware that it was not completed according to their expectation.

There was risk to both residents who were isolated on droplet contact precautions of missing symptoms and early intervention and isolation.

Sources: Progress notes; PCC; screening tool; observations; interviews with IPAC lead

[740898]

B) The licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented by not having followed the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022, regarding hand hygiene.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, April 2022, section 10.1 stated "The licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90 ABHR."

Public Health Ontario Fact sheet titled "Selection and Placement of ABHR during COVID-19 in Long-term Care and Retirement Homes" stated "Do not use expired product. Be sure to note product expiration date when selecting product."

During the initial tour of the home, forty-seven expired wall mounted Alcohol Based Hand Rub (ABHR) products were observed. During an observation of a snack cart, a bottle of Aloe Med hand sanitizer that was expired was observed. The staff member present with the cart confirmed that the product was expired and threw it away.

The Administrator stated during an interview, that it was the expectation that the Environmental Service Manager check the expiration of the ABHR monthly, but that no formal process had been implemented to ensure the checks were being completed.

During an interview, the IPAC Lead acknowledged they were aware of the expired ABHR products and that the home was working to replace them.

During an interview, Public Health (PH) representative stated that the risk was great for transmission of bacteria and infections due to the use of expired hand hygiene products.

During further observations, it was noted that the home had replaced the expired ABHR throughout the home.

Sources: Observations; Interviews with Administrator, IPAC Lead and PH representative.

[740895]

C) The licensee has failed to ensure that any standard issued by the Director with respect to IPAC was implemented.

Specifically, the licensee has failed to ensure that Routine Practices included the proper use of Personal Protective Equipment, including the appropriate selection and application as required by Additional Requirement 9.1 (d) under the IPAC Standard.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 9. 1 (d) that the licensee should ensure that Routine Practices and Additional Precautions included the proper use of Personal Protective Equipment (PPE), including the appropriate selection and application.

This inspector observed droplet contact signage posted on a resident room door. Directions were as follows:

- Wear mask and eye protection when within two feet of resident
- Wear gloves for direct care
- Wear long-sleeved gown for direct care
- Resident must wear a mask if they leave the room
- Dedicate equipment to resident or disinfect before use with another

This inspector observed staff enter the room, provide care to the resident, with gown, gloves, and medical mask only. They did not wear face shield or N95 mask.

During another observation, this inspector observed another staff member enter the room wearing a medical mask only for PPE, while they assisted the resident with care.

In an interview with the IPAC lead, they stated that their expectation for droplet contact precautions was N95 fitted mask, face shield, gown and gloves. They also stated that both residents in that room were on droplet contact precautions. In this interview, the IPAC lead confirmed their expectation when giving care to those residents on droplet contact precautions that the required PPE would be gown, gloves, face shield and N95 mask.

Failure to wear eye protection and N95 mask during care to a resident on droplet contact precautions may have increased the risk of transmission of infection into the home.

Sources: IPAC Standard for Long-Term Care Homes; signage; observations; interviews with staff.

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