Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901
central.west.sao@ontario.ca

Amended Public Report (A1)

Report Issue Date: November 3, 2022

Inspection Number: 2022-1016-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: CVH (No. 2) LP

Long Term Care Home and City: Maitland Manor, Goderich

Lead Inspector	**Inspector Digital Signature**
JanetM Evans (659)	Janet Evans Digitally signed by Janet Evans Date: 2022.11.04 08:32:37 -04'00'
Inspector who Amended	**Inspector who Amended Digital Signature**
JanetM Evans (659)	Janet Evans Digitally signed by Janet Evans Date: 2022.11.04 08:33:09 -04'00'

MODIFIED PUBLIC INSPECTION REPORT SUMMARY

This report was amended to remove error in finding FLTCA s. 24 (1).

INSPECTION SUMMARY

The Inspection occurred on the following date(s): October 3, 2022 – October 7, 2022

The following intake(s) were inspected:
- Intakes: #00001660, #00002232, #00002229, #00007187, #00007300 and #00005470 related to resident to resident abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to protect a resident from abuse by a co-resident.

Rational and Summary:
Complaints to the Ministry of Long Term Care (MLTC) alleged sexual abuse of a resident by a co-resident.

"Sexual abuse" is defined as any consensual or non-consensual touching, behavior or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member or any non-consensual touching, behavior or remarks or a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member. O. Reg. 246/22, s. 2 (1)

A resident verbalized to staff that a co-resident had touched them inappropriately.

A PSW said that the resident was negatively impacted by the incident.

The home's investigation substantiated sexual abuse had occurred to the resident.

This incident caused moderate emotional harm and physical discomfort to the resident.

Sources: Interviews with ED and staff, resident's progress notes, Critical Incident 0965-000007-22, home's investigative notes, Risk management noted, policy: Zero Tolerance of Resident Abuse and Neglect Program RC-02-01-01, last reviewed: January 2022.

[659]

WRITTEN NOTIFICATION: Policy of Zero Tolerance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (2) (e)

Non-compliance with FLTCA s. 25 (2) (e)

The licensee has failed to ensure that they had a clear and updated written policy in place to promote zero tolerance of abuse and neglect of residents, which contained procedures for their staff to follow when alleged, suspected or witnessed sexual abuse occurred, including the assessment of a resident for capacity to give consent.

Rationale and Summary
A) A critical incident was submitted to the Ministry of Long-Term Care (MLTC) related to an allegation of sexual abuse.

There was no documented assessment of the resident for capacity to provide consent at the time of the incident. [741750]

B) On two dates, incidents of inappropriate touching of the resident by resident #003 occurred.

There was no documented assessment of the resident for capacity to provide consent in relation to the touching, at the time of the incident. [706119]

The home's procedures for Zero Tolerance of Abuse and Neglect directed staff to assess the resident's capacity on a regular basis, especially if there was a significant change in the resident's condition. The policy did not provide specific procedures for staff related to how to determine if the sexual conduct was consensual or not at the time of the incident, so that they could determine if abuse had occurred or not.

Failing to have clear directions to staff related determining whether conduct at the time of the incidents were consensual or not, posed a risk of harm to the resident's health,

safety and well being.

Sources:
Interviews with ED and staff and resident #002, resident's progress notes, Critical Incident 0965-000005-22, Critical Incident 0965-000003-22, home's investigative notes, policy: Zero Tolerance of Resident Abuse and Neglect Program RC-02-01-01, last reviewed: January 2022.

WRITTEN NOTIFICATION: Duty of Licensee to comply with the plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. Specifically, the licensee failed to ensure that a resident had continuous monitoring by a staff member.

Rationale and Summary:
The resident's plan of care directed staff to provide continuous supervision at all times to monitor the resident.

Two observations showed there were no staff providing continuous supervision of the resident.

The ED said that staff were to ensure the resident was monitored and visible by the staff member at all times.

Failure to ensure the resident was monitored and visible by the staff member at all times put other residents at risk of harm.

Sources: Observations, plan of care, interviews with ED and staff. [659]

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (1) (a) Plan of care

The licensee shall ensure that the written plan of care for a resident set out the planned care for the resident related to safety.

Rationale and Summary
The home's policy of Zero Tolerance of Resident Abuse and Neglect, states they are to develop a comprehensive plan of care on admission, readmission, and at minimum quarterly thereafter, for residents with needs and behaviors that may lead to altercations, victimization or aggression and ensure all caregivers are aware of and compliant with its contents

The plan of care for the resident was updated following the first incident to include interventions of safety checks for three days. When a second incident occurred, the plan of care was updated to include interventions of safety checks for five days. There were no ongoing interventions in the resident's plan of care to protect them from further incidents.

An RN confirmed that the resident's plan of care was not updated and should have been, with ongoing safety checks, identification and monitoring for encounters with other residents.

Failure to update the resident's plan of care to monitor the resident for safety related to interaction with other residents, resulted in a further incident of inappropriate touching.

Sources: Interview with an RN, record review of resident's care plan and progress notes, Zero Tolerance of Resident Abuse and Neglect Program RC-02-01-01, last reviewed: January 2022.

[706119]

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)

The licensee has failed to ensure that the standard issued by the Director with respect to IPAC, was implemented. Specifically they failed to ensure:
- appropriate signage was posted for additional precautions
- staff wore the appropriate PPE when providing care to residents with additional precautions and
- staff encouraged or assisted residents with hand hygiene prior to meals.

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.

Rationale and Summary:
A) The IPAC Standard for LTCHs, dated April 2022, states that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. Section 9.1 (e) states point-of-care signage indicating that enhanced IPAC control measures are in place.

The home's IPAC program included signage for additional precautions be posted at the entrance to resident rooms as required.

On October 3 and 6, 2022, no point of care signage was noted outside of a room for resident with a confirmed infection.

The ADOC acknowledged there should have been signage for additional precautions required at the point of care for the resident.

Failure to ensure signage for additional precautions is posted at the point of care for residents as required, puts staff, visitors and other residents at risk of spreading infectious pathogens.

Sources: observations, Extendicare IPAC program-October 2019, interview with DOC.

B) The IPAC Standard for LTCHs, dated April 2022, states that the licensee shall

ensure that Routine Practices and Additional Precautions are followed in the IPAC program. Section 9.1(f) Additional Precautions at a minimum, include PPE requirements including appropriate selection application, removal and disposal.

Resident #009 was on contact precautions as they were positive for ESBL.

On October 7, 2022, two PSW's were observed entering a resident's room to assist the resident with care. Signage posted at the entrance to the resident's room indicated that a gown, gloves and mask should be worn. The PSWs did not wear a gown as directed by the signage for additional precautions.

Numerous staff said it had not been communicated to them that the resident was on IPAC precautions.

Failure to identify the need for additional precautions when caring for the resident and failure of staff to use the appropriate PPE may increase the potential risk for spread of infectious disease pathogens.

Sources: observations, Dynacare lab test dated August 16, 2021,interview with Administrator, ADOC and staff.

C) The IPAC Standard for LTCHs, dated April 2022, section 10.4(h), states 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 policy for hand hygiene directs staff to assist or encourage residents with hand hygiene prior to and following meals.

On October 4, 2022, dining observations showed staff did not encourage or assist residents with hand hygiene prior to the lunch meal.

A resident said they did not recall seeing staff encourage or assist other residents to sanitize their hands prior to meals.

A PSW said they were supposed to cleanse residents' hands and face with a warm towel after meals. A RPN said hand sanitizer was available on meal tables for staff to assist and encourage residents to perform hand hygiene before and after meals.

There is potential impact to residents and staff of the spread of infectious disease pathogens when hand hygiene is not completed.

Sources: observations, Hand hygiene policy, Extendicare, IC-02-01-08 policy last reviewed June 2021, interviews with DOC, ED, staff and resident #007. [659]