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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: April 4, 2024	
Inspection Number: 2024-1490-0001	
Inspection Type: Follow up	
Licensee: The Governing Council of the Salvation Army in Canada	
Long Term Care Home and City: R. H. Lawson Eventide Home, Niagara Falls	
Lead Inspector Cathy Fediash (214)	**Inspector Digital Signature** Catharine M Fediash Digitally signed by Catharine M Fediash Date: 2024.04.09 09:40:51 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 18, 19, 21, 22, 25, and 26, 2024.

The following intake(s) were inspected:

- Intake: #00106838 -Follow-up to CO#001 from Inspection #2023-1490-0004 regarding FLTCA, 2021 - s. 184 (3) related to masking protocols, CDD : February 28, 2024.
- Intake: #00106837 -Follow-up to CO#002: from Inspection #2023-1490-0004 regarding O. Reg. 246/22 - s. 93 (2) (b) (i) related to housekeeping (cleaning of mechanical lifts), CDD: February 22, 2024
- Intake: #00106836 -Follow-up to CO#003: from Inspection #2023-1490-0004 regarding O. Reg. 246/22 - s. 102 (2) (b) related to Infection Prevention and Control, CDD: March 7, 2024.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #003 from Inspection #2023-1490-0004 related to O. Reg. 246/22, s. 102 (2) (b) inspected by Cathy Fediash (214)

Order #002 from Inspection #2023-1490-0004 related to O. Reg. 246/22, s. 93 (2) (b) (i) inspected by Cathy Fediash (214)

Order #001 from Inspection #2023-1490-0004 related to FLTCA, 2021, s. 184 (3) inspected by Cathy Fediash (214)

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Binding on Licensees

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 184 (3)

Directives by Minister

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 has failed to ensure they carried out every operational or policy directive that applied to the long-term care home.

Rationale and Summary

In accordance with Ministers Directive: COVID-19 response measures for long-term care homes, homes were to conduct regular Infection Prevention and Control (IPAC) audits, in accordance with the COVID-19 guidance document for long-term care homes in Ontario. This guidance document indicated the IPAC Self-Assessment Audit for Long-Term Care Homes, was to be completed weekly, when the home was in outbreak.

The home submitted a Critical Incident System (CIS) report, that had identified the home was experiencing an outbreak.

A review of the IPAC Self-Assessment audits conducted by the home and confirmation with staff, indicated an audit had not been completed for a specified week, as required during an outbreak.

When IPAC audits are not completed as required during an outbreak, this has the potential for the home to not be able to accurately assess if their IPAC practices meet the minimum requirements under the applicable legislation and regulations. It also has the potential to result in inaccurate audit results, when comparing audits to assess if areas for improvement have been addressed.

Sources: CIS report, home's IPAC self-assessment audits, and an interview with the IPAC manager. [214]

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 (9) (b)

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,

(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee has failed to ensure that when a resident demonstrated symptoms of infection, the symptoms were recorded on every shift.

Rationale and Summary

The licensee was to ensure that on every shift, symptoms indicating the presence of infection were monitored in accordance with any standard or protocol issued by the Director.

The IPAC standard for Long-Term Care homes, indicated the licensee's requirement to implement surveillance protocols for a particular communicable disease or disease of public health significance.

The IPAC manager and Director of Care (DOC) indicated when a resident was diagnosed with a specified disease diagnoses, staff were to document symptoms indicating the presence of infection in a specified assessment.

A review of a resident's clinical records indicated they had been diagnosed as having a disease of public health significance. Assessments and progress notes indicated that symptoms were documented as occurring on six specified dates. The symptoms were recorded on two shifts.

It was confirmed the home had three nursing shifts in a 24-hour period and that the resident's symptoms of infection had only been documented on two of the shifts.

When symptoms indicating the presence of infection are not documented on every shift, this has the potential of not accurately assessing a decline or improvement of the resident's status and/or accurately analyzing the data collected to detect trends.

Sources: A resident's specified assessments, progress notes, and interviews with the IPAC Manager and DOC. [214]