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

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

Original Public Report

Report Issue Date: September 10, 2024
Inspection Number: 2024-1490-0002
Inspection Type:
Critical Incident

Licensee: The Governing Council of the Salvation Army in Canada
Long Term Care Home and City: R. H. Lawson Eventide Home, Niagara Falls

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 23, 26 - 29, 2024

The following intake(s) were inspected:

- Intake: #00121013 (CIS: 2991-000015-24) related to infection prevention and control,
- Intake: #00123374 (CIS: 2991-000016-24) related to resident care and services.

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

Resident Care and Support Services
Infection Prevention and Control

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care for specific activities were documented for a resident.

Rationale and Summary
A resident had a severe cognitive impairment and required staff assistance for several activities of daily living. Staff were to document care provided and document when the resident indicated pain and changes in behavior on every shift.

The resident sustained an injury of unknown cause on a specified date that required hospitalization and surgical intervention. Documentation Survey Report was reviewed and indicated care activities on several dates were not documented. Staff and the Director of Care confirmed that care provided, and indicators of pain and behavior changes were to be documented.

When documentation was incomplete, there was a low risk of unidentified pain and that the residents injury and subsequent pain was not addressed in a timely manor.

Sources: Review of resident's clinical record; interviews with staff and the Director of Care. [740873]

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 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

Rationale and Summary
The IPAC lead has failed to ensure that following the resolution of an outbreak, a summary of findings was created that made recommendations to the licensee for improvements to outbreak management practices in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, a summary of findings was not created after a respiratory outbreak in July 2024 that made recommendations to the licensee for improvements to outbreak management practices as is required by Additional Requirement 4.3 under the IPAC Standard. The IPAC lead stated the home had not discussed IPAC practices that were effective and ineffective in the management of the outbreaks.

When a summary of findings pertaining to IPAC practices that were effective and ineffective in the management of the outbreak was not created, there is risk of ineffective outbreak management practices carried forward to future outbreaks.

Sources: Interview with IPAC lead. [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 (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 resident's symptoms were recorded, and that immediate action was taken to reduce transmission and isolate residents and place them in cohorts as required.

Rationale and Summary
The local Public Health unit declared a specified home area for a respiratory outbreak between July and August 2024. A resident experienced respiratory symptoms on a specified date, and was isolated the following day.

The home's policy stated symptoms indicating the presence of infection in residents were to be monitored and recorded on every shift. The resident symptoms were not monitored and recorded on every shift on two identified dates. A staff and the IPAC lead acknowledged the resident's symptoms were not monitored and recorded on every shift, and stated that they should have been.

When symptoms were not recorded every shift, there was a risk that the resident was not monitored for changes and there was a potential delay in immediate action to reduce transmission.

Sources: Record review of resident's clinical record; interview with staff and the IPAC lead. [740873]

COMPLIANCE ORDER CO #001 Housekeeping

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

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

1. Provide training for housekeeping staff on the home's procedure for cleaning resident rooms and washrooms on additional precautions; and
2. Maintain record of the training provided, including the date and signature of the staff members who the training was provided to, and who provided the education; and

3. Conduct audits on the cleaning of resident rooms and washrooms on additional precautions as per the home's policy for at least two weeks, or until no concerns are identified; and
4. Maintain record of the audits conducted, including actions taken to address any identified concerns, and keep a record of these audits for inspector review.

Grounds
The licensee did not ensure the implementation of cleaning procedures for resident bedrooms, which include floors, carpets, furnishings, privacy curtains, contact surfaces, and wall surfaces.

Per O. Reg 246/22, s.11 (1) (b), the licensee was obligated to ensure that staff performed a first and second cleaning of the residents' rooms under additional precautions, following the home's Environmental Services for Infection Prevention and Control Policy.

Rationale and Summary
The local Public Health unit announced a respiratory outbreak in a specified home area twice between July and August 2024. According to the home's policy, surfaces in bedrooms and washrooms under additional precautions were to be cleaned first. Staff were then to conduct a routine daily cleaning of rooms and washrooms not under precautions, followed by a routine cleaning of rooms under additional precautions. Lastly, staff were to disinfect all surfaces with wipes.

Housekeeping staff reported that rooms under additional precautions only underwent routine daily cleaning. During the inspection, the third-floor home area

was in a respiratory outbreak with several resident rooms under additional precautions.

The Director of Environmental Services acknowledged that the required cleaning was not being completed by the staff.

Failure to clean the residents' rooms under additional precautions as per the policy increased the risk of spreading infectious agents in the home areas. There was impact to the residents health and well-being when the home area entered a subsequent respiratory outbreak.

Sources: Interviews with staff, and the Director of Environmental Services; record review of the home's policy home's policy titled "Environmental Services for Infection Prevention and Control", Appendix D, Outbreak Procedure for Cleaning Resident Rooms and Washrooms on Additional Precautions (Droplet, Contact or Airborne), revised November 4, 2023. [740873]

This order must be complied with by October 22, 2024.

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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

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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.