Ontario

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

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702
centraleastdistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: December 16, 2022

Inspection Number: 2022-1592-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: The Corporation of the City of Kawartha Lakes

Long Term Care Home and City: Victoria Manor Home for the Aged, Lindsay

Lead Inspector	**Inspector Digital Signature**
Nicole Jarvis (741831)	Nicole Jarvis Digitally signed by Nicole Jarvis Date: 2022.12.22 14:01:49 -05'00'

Additional Inspector(s)
Patricia Mata (571)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):

October 27-28, 31, and November 1-4, 7-9, 14-18, 2022.

The following intake(s) were inspected:

Intake: #00001065; Intake: #00001547; Intake: #00001658; Intake: #00006276; Intake: #00007380; Intake: #00010987; Intake: #00011122 - related to resident-to-resident abuse.
Intake: #00001500; Intake: #00002829 - related to falls.
Intake: #00004433 - related to missing resident.
Intake: #00004500 - Complaint related to safe lift and transfers, medication administration, pain management, and care support.

The following intake(s) were completed in the Critical Incident System Inspection:

Intake: #00001155; Intake: #00001366; Intake: #00006190 related to missing resident; and Intake: #00005215; Intake: #00005463; Intake: #00005464; Intake: #00001036 related to falls.

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

Infection Prevention and Control
Resident Care and Support Services
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Falls Prevention and Management
Safe and Secure Home
Medication Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.

The licensee has failed to ensure their hand hygiene program included the removal of expired hand hygiene agents to maintain the 70% to 90% alcohol content.

Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.1 states that the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

Rationale and Summary

Observations of Infection Prevention and Control (IPAC) practices were made throughout the inspection.

Expired hand sanitizer was observed in use by the front entrance, the screening kiosk, the entrance of identified isolation precaution rooms, the educational room and in Resident Home Areas on the handrails.

When Screener and Acting Director of Care became aware of the expiry date of the Alcohol-Based Hand Rub, it was removed from the location. The Acting Director of Care was unable to confirm that the expired ABHR maintained the percentage of 72% alcohol content after the expiry date was noted.

When the licensee was unable to confirm that the expired Alcohol Based Hand Rub maintained a 70-90% alcohol content at the time of the inspection, there was a potential risk of ineffective hand hygiene and risk for transmission of infectious agents including the COVID-19 virus.

Sources: Interviews with Screener, Acting Director of Care, observations throughout resident common areas.
[741831]

WRITTEN NOTIFICATION: Security of drug supply

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 1.

The licensee failed to ensure that medicated treatment creams are kept locked at all times, when not in use.

Rational and Summary

During the inspection, it was observed in a resident home area, that medicated treatment creams were accessible and not locked on October 27, 2022, and November 18, 2022.

Medicated treatment creams were observed on the side of a mobile care cart on the Resident Home Areas. A padlock was available for staff to lock the medication in a secure location.
PSW and Acting Director of Care confirmed that the treatment creams are required to be kept under lock at all times, when not in use.

Sources: Interviews with PSW and Acting Director of Care, observation of medication storage.
[741831]

WRITTEN NOTIFICATION: Administration of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee failed to ensure resident #001 received their medication as prescribed.

Rational and Summary

Resident #001 was not provided with their scheduled medication on one occasion.

On a specified date, a review of the resident's medical records indicated five specific medications were administered once. The physician prescribed administration of the medication twice daily.

The acting Director of Care indicated their expectation would be that medication was administered as prescribed.

By failing to ensure medications were administered to a resident twice daily as prescribed, RPN #126 was putting the resident at a potential risk for a negative outcome.

Sources: Interviews with resident #001, an RPN, acting DOC and medical record review, including eMAR. [571]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 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 implement any standard or protocol issued by the Director with respect to infection prevention and control.

1.) Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 9.1 (d) states that the proper use of Personal Protective Equipment, including appropriate selection, application, removal, and disposal, are followed in the IPAC program as required.

Rational and Summary

The IPAC Lead stated that the screener is required to wear eye protection, gloves, mask, and a gown during screening activities including completing a rapid-antigen test on others.

Inspector observed a Screener conducting a Rapid-Antigen test on a visitor, without the application of eye protection and a gown during an Outbreak in the home. Screener stated there is a requirement for the additional Personal Protective Equipment when conducting a Rapid-Antigen test; however, when they get busy, they do not always apply it.

By conducting improper Personal Protective Equipment selection, application, removal, and disposal, there was a risk of the transmission of infectious agents including COVID-19.

Sources: Interviews with Screener, Associate Director of Care (ADOC)/ Infection Prevention and Control (IPAC) Lead, observations of IPAC practices at the home.
[741831]

Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

The licensee failed to ensure the implementation of any standard or protocol issued by the Director with respect to Infection Prevention and Control.

2.) Minister's Directive: COVID-19 response measures for Long-Term Care homes 1.1 (Effective August 30, 2022) states that the licensee requires the completion of IPAC audits every two weeks unless in outbreak. When a home is in outbreak, IPAC audits must be completed weekly. At minimum, homes must include in their audits the Public Health Ontario's COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes.

A record review of Infection Prevention and Control (IPAC) practices were made throughout the inspection.

ADOC/ IPAC Lead stated that the home completes the *Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes* bi – weekly. If the licensee is experiencing an outbreak the audit is completed weekly as per the Minister's Directive.

During record review the following *Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes were* completed: September 14, September 30, October 4, October 11, November 3, and November 7.

It was confirmed by the ADOC/IPAC Lead that in the period of October 11, 2022, to November 3, 2022, there was no audit completed. The home was declared in a COVID-19 Outbreak on November 4, 2022,

by their local Public Health Unit.

Sources: Record review, and interview with ADOC/IPAC Lead.
[741831]

COMPLIANCE ORDER CO #001: Duty to Protect

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

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 FLTCA, 2021, s. 24 (1).

Specifically, the licensee must:

(1) Ensure that resident #006 is provided the use of a specified assistive device at their request.

(2) Ensure resident #006 is using the identified assistive device in a safe manner, with one to one supervision at all times as specified.

(3) Ensure that a record is kept of the dates, time and name of the staff members who provide the assistance. The record is to be made available to Inspectors upon request.

(4) Ensure that when resident #006's declines to use the assistive device, there is clear documentation to support the reason why.

(5) Ensure that resident #006's ability to use the assistive device, is continued to be assessed at least quarterly and at any other time their ability declines.

Grounds

The licensee has failed to protect co-residents from injury by a resident, while the resident was using an assistive device.

Section 2 (1) of the Ontario Regulation 246/22 defines physical abuse by a resident as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary

One four occasions, resident #006 showed inappropriate behaviour that caused injury or a potential for injury to co-residents when using their assistive device.

The care plan for the resident indicated the resident had the potential to display responsive behaviours when triggered.

A review of medical and licensee records and interviews with the Physiotherapist (PT) and acting Director of Care (DOC) indicated the resident had been assessed and was determined to be capable of using the assistive device. The licensee determined that the resident used their assistive device inappropriately causing harm to co-residents. An interdisciplinary team implemented a plan to prevent further injury to co-residents. The plan failed to consider the resident's responsive behaviour.

By failing to protect the residents of the home by not ensuring resident #006 is no longer able to harm residents with their assistive device, the licensee is placing residents at risk of harm.

Sources: Interviews with the Physiotherapist and the acting Director of Care, a review of progress notes, care plans, incident reports and meeting minutes.
[571]

This order must be complied with by January 15, 2023

COMPLIANCE ORDER CO #002 Transferring and positioning techniques

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O.Reg. 246/22, s. 40

Non-compliance with O. Reg. 79/10, s. 36 under the Long-Term Care Homes Act (LTCHA), 2007 and O. Reg. 246/22, s. 40 under the Fixing Long-Term Care Act, (FLTCA), 2021.

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, which repealed and replaced the O. Reg. 79/10 and the LTCHA. As set out below, the licensee's non-compliance occurred prior to April 11, 2022, where the requirement was under s. 89 (1) (a)(iv) of O. Reg. 79/10. Non-compliance also occurred after April 11, 2022, which falls under s. 95 (1)(a)(iv) of O. Reg. 246/22 under the FLTCA.

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 O/Reg. 246/22, s. 40.

Specifically, the licensee shall:

1) Ensure all residents who use a specified assistive device, regardless of the source, receive training on the use of the device and an assessment determining if they can safely use the device and keep a documented record of the training and assessments, including occurrence date, by whom as well as attendees and make available to inspectors upon request.

2) Ensure all residents who use the specified assistive device, are re-evaluated by a professional who is authorized to perform such an assessment, at least quarterly and at any other time the resident's ability declines.

3) Audit PSW #123 and #124 for safe transferring and positioning, three times in a one-month period while transferring the resident. Keep a documented record of the audits, including when the audits occurred, by whom as well as attendees and make available to inspectors upon request.

Grounds

The licensee has failed to ensure staff used safe transferring technique when transferring resident #001.

Rationale and Summary

A review of medical and licensee records and interviews indicated that resident #001 had received a new assistive device.

The Physiotherapist indicated they had been informed by a vendor that resident #001 would be receiving a new assistive device and an Occupational Therapist from an outside agency would be there to assess resident #001's skills when using the device. If the OT found that the resident was safe while using the assistive device, they would leave the device.

Resident #001 was assisted while using the device by two staff members. While they were assisting the resident, an incident occurred which caused the resident to be injured.

The acting DOC indicated that they and the Physiotherapist had noted after the incident that resident #001's assistive device needed to be adjusted or the incident could occur again. Before the resident started using the assistive device again, the vendor was to have come in and determine if the device needed to be adjusted.

The Physiotherapist stated resident #001 had arranged for the delivery of the assistive device with the vendor themselves rather than going through the Physiotherapist. Normally when a new assistive device was delivered to a resident, the physiotherapist first explained and showed the resident how to use the assistive device safely and assessed the resident. The physiotherapist determined when and if the resident can safely use the assistive device before they are allowed to use it. When the resident is ready to use the device, the staff are trained on how to use the assistive device as well. Staff are to wait until the resident is assessed and until the staff receive education.

The acting DOC stated that the two members had not received training before assisting resident #001

By not ensuring that the resident #001 was completely trained and assessed while using the assistive device and by not ensuring that the two staff members that assisted the resident had education on how to use the device, the licensee was putting the resident at risk of injury.

Sources: Interviews with resident #001, Physiotherapist, acting DOC, and one PSW, progress notes, and licensee investigation file.
[571]

Non-compliance with: O. Reg. 79/10, s. 36.

The licensee has failed to ensure staff used safe transferring technique when transporting resident #001 and #005.

Rationale and Summary

The acting Director of Care (DOC) indicated they became aware that staff had been transferring residents #001 and #005 in an unsafe manner. A PSW had informed the acting DOC that was how residents #001 and #005 had always been transferred. The licensee immediately provided education to staff that they were incorrectly transferring the residents.

By not ensuring staff did not use unsafe transferring methods, residents #001 and #005 were placed at risk for possible injury.

Sources: Interviews with resident #001 and the acting DOC.
[571]

This order must be complied with by February 15, 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.