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

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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: January 17, 2024	
Original Report Issue Date: December 21, 2023	
Inspection Number: 2023-1592-0003 (A1)	
Inspection Type: Complaint Critical Incident	
Licensee: The Corporation of the City of Kawartha Lakes	
Long Term Care Home and City: Victoria Manor Home for the Aged, Lindsay	
Amended By Tiffany Forde (741746)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to:
Change the Compliance Due Date of CO #001 from January 24, 2024, to February 29, 2024, at the long-term care home's request.

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Lead Inspector Lynda Brown (111)	**Additional Inspector(s)** Tiffany Forde (741746) Holly Wilson (741755)
Amended By Tiffany Forde (741746)	**Inspector who Amended Digital Signature**

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 15 to 17, 20 to 24 and 27 to 29, 2023

The following intake(s) were inspected:

- Intake: #00019281 (CIR), Intake: #00020710 (CIR) and Intake: #00088220 (CIR): related to resident to resident abuse.
- Intake: #00088753 (CIR): related to an injury for which a resident was transferred to hospital and resulted in a significant change in condition.
- Intake: #00096623 (CIR): related to severe hypoglycemia/unresponsive hypoglycemia of a resident.
- Intake: #00098677 - Complaint regarding residents rights.
- Intake: #00088272 - Complaint regarding 24-hour nursing care, nutrition and hydration, and air conditioning.

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

Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Staffing, Training and Care Standards
Residents' Rights and Choices
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: 24-hour nursing care

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

Non-compliance with: FLTCA, 2021, s. 11 (3)

Nursing and personal support services
24-hour nursing care
s. 11 (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

The licensee failed to ensure there was at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

Rationale and Summary

An anonymous complaint was received by the Director regarding no Registered Nurse (RN) on duty and present in the home.

Review of the Daily staffing reports for a period months in 2023, indicated there were a number of dates and shifts where there was no RN on duty and present in the home.

During an interview with an RN, they confirmed awareness of several dates/shifts where there was no RN on duty and present in the home and occurred mainly on specified shifts due to job vacancies. They indicated the home's practice was to replace with an RN from agency and if not available, they replaced with an RPN with the manager on-call. The RN confirmed the manager on call was not always an RN.

Interview with the DOC indicated they had not been in the role for very long, approximately six months, and was aware of issues with no RN on duty and present in the home.

Failing to ensure there is an RN on duty and present in the home placed residents at risk.
Sources: staffing schedule reports and interview of staff [111].

WRITTEN NOTIFICATION: Accommodation Services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
Specific duties re cleanliness and repair
s. 19 (2) Every licensee of a long-term care home shall ensure that, (c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Rationale and Summary
During the inspection, observations by Inspector #741755 on a resident home area (RHA) noted a loveseat in the main resident lounge that was in a state of disrepair. The vinyl seating of the sofa was worn off on a large portion of the two seats of the sofa.

The home had a process to report repairs on the computer though Maintenance Care and was to discard any furnishings that could not be repaired.

During an interview with the Environmental Services Manager (ESM) and a housekeeper, they confirmed the sofa was in disrepair and should have been discarded.
By not maintaining resident furniture in a good state of repair, placed the residents' safety at risk.
Sources: observations; interview with ESM and a housekeeper.[741755]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours, (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that, for resident #001 who was demonstrating responsive behaviours, that actions were taken to respond to the needs of the resident, including reassessments.

Rationale and Summary
The Director received a critical incident report (CIR) regarding a resident-to-resident abuse incident between resident #001 and #002. The CIR indicated resident #002 sustained an injury to a specified area as a result. Prior to the incident staff were aware of resident #001 responsive behaviours and triggers. At the time of the incident, staff attempted redirection of resident #001 without success and no other actions were taken which resulted in the incident.

The Director received a second CIR regarding a resident-to-resident abuse incident involving resident #001 and #004. The CIR indicated resident #004 sustained an injury to a specified area as a result. The CIR indicated there were no actions taken to address resident #001's grooming needs in the plan of care that resulted in the injury to resident #004.

Review of the home's Responsive Behaviours Management Policy indicated the nurse was to complete an electronic responsive behaviour referral whenever there was a new or change in responsive behaviours to assist in developing additional actions to address the behaviours.

During separate interviews with the BSO and the DOC, they confirmed a referral should have been sent after each incident in order for reassessment to occur and was not completed until after the second incident of resident-to-resident abuse. Failing to ensure that actions were taken, including reassessments by BSO to respond to the needs of resident #001, who was demonstrating responsive behaviours towards other residents, resulted in resident #002 and #004 sustaining injuries.

Sources: two CIR's, resident #001, #002 and #004 health records, Responsive Behaviours Management Policy and interviews with staff. [741746]

WRITTEN NOTIFICATION: Changes in direction for administration

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

Non-compliance with: O. Reg. 246/22, s. 136

Changes in directions for administration

s. 136. Every licensee of a long-term care home shall ensure that a policy is developed and approved by the Director of Nursing and Personal Care and the

pharmacy service provider and, where appropriate, the Medical Director, to govern changes in the administration of a drug due to modifications of directions for use made by a prescriber, including temporary discontinuation.

The licensee has failed to ensure that a policy that was developed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director, in the administration of a drug due to modifications of directions for use made by a prescriber, was complied with.

In accordance with Ontario Regulation 246/322 s.11(1)(b) where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

Rationale and Summary
The Director received a CIR indicating resident #005 had a medical event and required a medication administration with transfer to hospital.

A physician's order dated prior to the incident, directed nursing staff to hold the resident's specific medication if the resident did not consume their meal. This order was signed off by two nursing staff the same day attesting they had transcribed the order to the Medication Administration Record (MAR).
The home's policy for transcribing prescriber's orders indicated that physician orders are to be transcribed accurately and completely to the MAR and the nursing staff were to discontinue the existing order, and add then add the new order to the MAR.
During an interview with an RPN, they acknowledged the new physician order for resident #005 should have been transcribed onto the MAR. The DOC confirmed the physician order for resident #005 was not transcribed as required and the MAR was

not updated with the new direction.
By failing to transcribe resident #005's new physician orders and update the MAR resulted in a delay of the resident obtaining appropriate treatment.

Sources: CIR, resident #004's health records, Transcribing Prescriber's Orders policy and interviews with staff. [741746]

(A1)

The following non-compliance(s) has been amended: NC #005

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee will comply with O.Reg. 246/22, s. 102 (2)(b).

Specifically, the licensee shall:

1.Conduct daily hand hygiene, PPE use and cleaning of high-touch surfaces audits on each unit for two weeks, then three times a week for two weeks or until compliance is achieved. Complete on the spot re-training with staff who have been found to be non-compliant with hand hygiene, PPE use and cleaning of high-touch surfaces practices. The audits are to include staff names who were provided with

re-training. The audits are to be provided to the Inspectors immediately upon request.

Grounds

1.The licensee failed to ensure that any standard issued by the Director with respect to infection prevention and control (IPAC) were complied with regarding hand hygiene practices.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, revised September 2023". IPAC Standard 9.1 directs the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include b) Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Rationale and Summary

On November 17, 2023, Inspector #111 observed on the Macmillan Resident Home Area (RHA), RPN # 117 entering room 104 without performing hand hygiene. The RPN entered the room to speak to the resident and retrieve their phone that had been left in the residents bed. The home was experiencing a home-wide COVID-19 outbreak at the time of the observation.

During an interview with the IPAC Lead, they confirmed the expectation for all staff to complete hand hygiene prior to entering and upon exiting resident rooms.

Failure to complete hand hygiene at the four moments of hand hygiene, places residents at risk of harm due to transmission of infections.

Sources: observation and interview with IPAC Lead. [111]

2.The licensee failed to ensure that any standard issued by the Director with respect to IPAC was complied with in regards to PPE use.

In accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes, revised September 2023". IPAC Standard 6.7, directs Additional Requirement under Masking: the Licensee shall ensure that all staff, students, volunteers and support workers comply with applicable masking requirements at all times.

Rationale and Summary
On November 15, 2023, during the lunchtime meal service, Inspectors observed numerous staff and visitors on the Vaga RHA wearing N95 masks, medical masks, or coming onto the RHA while donning a medical mask. It was also observed that staff, visitors and management were wearing medical masks throughout the home.

The home was in an ongoing COVID-19 outbreak since October 24, 2023. On November 3, 2023 Public Health Ontario declared a facility wide outbreak and an email was sent to all staff from the IPAC Lead confirming the home was in a facility wide COVID-19 outbreak and all staff are to wear N95 masks at all times.

The Registered Practical Nurse (RPN) #103 was observed entering the Vaga RHA while donning a medical mask. Upon seeing the Inspector, they then donned a N95 mask. The RPN indicated they were confused about the appropriate masks they were required to apply. The RPN then provided an email that verified the staff were to don N95 masks.

The IPAC Lead confirmed that the home was in an ongoing COVID-19 outbreak and

N95 masks are to be worn only on affected RHA's or when with residents on isolation for COVID-19. They indicated that the Vaga RHA had resolved their outbreak and no longer required the use of N95 masks unless a point of care risk assessment required the use of one. The IPAC lead later confirmed that Public Health issued a facility-wide COVID-19 outbreak which included that all staff and visitors were to be using N95 masks.

Failing to ensure staff donned the appropriate masks during a COVID-19 facility-wide COVID-19 outbreak in home, placed residents at risk for further transmission of infection.

Sources: Observations, internal emails from Public Health Ontario, and interviews with RPN #103 and IPAC Lead. [741755]

3.The licensee failed to ensure that any standard issued by the Director with respect to IPAC was complied with in regards to environmental cleaning procedures.

In accordance with IPAC Standard 9.1 directs the licensee to ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At a minimum Routine Practices shall include (g) modified or enhanced environmental cleaning procedures.

Rationale and Summary
During the inspection, the home was in a facility-wide COVID-19 outbreak that was declared by PHO on October 24, 2023.

During the initial tour of the home, Housekeeper (HSK) #102 indicated there was a process to identify and clean high-touch surfaces twice daily during the outbreak. They provided the daily log of the housekeeping Frequency Cleaning Schedule for

the month of November 2023 which was to be completed by the housekeeper.

During an interview with HSK #102, they confirmed that from November 1-12, 2023, the log was blank suggesting the cleaning had not been completed. They confirmed they had worked on November 13-14, 2023 and had only documented daily cleaning and had missed completing the remained of the log. The HSK could not recall if they had completed the twice daily cleaning.

An interview with the Environmental Services Manager (ESM) indicated that high-touch surface cleaning should have been completed twice daily, but only completed a monthly audit of the frequency of cleaning, despite the requirement of audits completed every two weeks.

During two separate interviews with IPAC Lead #101, they confirmed no awareness of how often high-touch surfaces should have be cleaned, especially during an outbreak.

Failure to identify the need for enhanced environmental cleaning of high-touch surfaces a minimum of twice daily, during an outbreak, placed the residents at risk of contracting illness.

Sources: Observations and interviews with the IPAC Lead #101, HSK #102 and the ESM. [741755]

This order must be complied with by February 29, 2024

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.