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

North District
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Original Public Report

Report Issue Date: August 30, 2023	
Inspection Number: 2023-1614-0003	
Inspection Type: Complaint	
Licensee: Corporation of the Town of Kirkland Lake	
Long Term Care Home and City: Teck Pioneer Residence, Kirkland Lake	
Lead Inspector Karen Hill (704609)	**Inspector Digital Signature** Karen L Hill Digitally signed by Karen L Hill Date: 2023.09.15 15:52:05 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on July 31, 2023, and August 1-2, 2023.

The following two intakes were inspected:

- One intake related to concerns about the LTCH operations and resident care; and
- One intake related to concerns about the residents' survey and staffing shortages.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Infection Prevention and Control
Staffing, Training and Care Standards
Quality Improvement

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of

section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 85 (3) (p)

The licensee has failed to ensure that the most recent minutes of Residents' Council (RC) meetings were posted in the home.

Rationale and Summary
During an initial tour of the home, the most recent minutes of the RC meeting were not posted.

The Life Enrichment Manager (LEM) acknowledged that they were aware of the requirement to post the most recent minutes of the RC meeting; yet had not done so.

The minutes of the RC meeting were observed posted, prior to the completion of the inspection.

There was minimal impact or risk to the residents when the licensee failed to ensure that the most recent minutes of the RC meeting was posted in the home.

Sources: Observations of RC boards; and interviews with residents, LEM, and the Executive Director (ED).

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Date Remedy Implemented: August 1, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 271 (1)

The licensee has failed to ensure the home's website that was open to the public, included the minimum requirements as outlined in O. Reg. 246/22 s. 271 (1).

Rationale and Summary
On the first day of the inspection, the home's website did not include any of the information as outlined in s. 271 (1) of the O. Reg. 246/22.

The ED acknowledged that the home's website did not contain the required information; that once they were made aware, they ensured that the website included the missing information.

The required content was posted on the home's website, prior to the completion of the inspection.

There was minimal risk to the residents and their families when the licensee failed to ensure that the required information was included on the home's website.

Sources: Review of the home's public website, the minutes of Family Council (FC) meeting; and interviews with the ED and other staff members.

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Date Remedy Implemented: August 1, 2023

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 5.

The licensee has failed to ensure that the rights of a resident were fully respected and promoted, including the right to be free from neglect from the licensee and staff, when the staff did not provide assistance when requested, within a reasonable time.

Rationale and Summary
A resident's plan of care indicated that they required a specific type of assistance from staff for an activity of daily living (ADL).

At two different times, on a specified date, the resident rang their call bell for assistance, but the resident did not receive the assistance they required.

The resident described how they often waited for long periods of time after activating their call bell for someone to assist them; requiring them to perform the ADL by themselves. A family member reported to the inspector that when the resident had to wait for the assistance, the resident's personal dignity was diminished.

Staff members verified that at times, they did not respond to requests for assistance right away that were made by way of the call bell system.

The Director of Care (DOC) acknowledged that the response times were not acceptable; that it was the

responsibility of specific staff members to answer the activated call bells, when other staff members were unable to.

When staff failed to respond to a resident's call bell in a timely manner, it impacted the resident's safety, personal dignity, and well-being, as the assistance they required was not provided as needed.

Sources: Residents' clinical health records, the home's call bell audit records, and the home's policy titled, Personal Response System Overview; and interviews with a family member, residents, the DOC and other staff members.

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WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (1)

The licensee has failed to ensure that, unless otherwise directed by the Minister, at least once in every year a survey was taken of the residents, their families/caregivers to measure their experience with the home and the care, services, programs, and goods provided at the home.

Rationale and Summary
The minutes of a recent Residents' Executive Council (REC) meeting, indicated the an annual experience survey was not provided to residents or families/caregivers since 2020.

The ED confirmed that the annual survey had not been provided to the residents or families/caregivers in the last calendar year.

Failing to provide the resident or families/caregivers an annual survey, impacted the residents and their families/caregivers ability to improve service delivery by providing the home with feedback.

Sources: The minutes of REC meeting, minutes of Family Council (FC) meeting; and interviews with residents, the ED, and other staff members.

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WRITTEN NOTIFICATION: Duty to Respond

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 63 (3)

The licensee has failed to respond to the RC, in writing, within 10 days of being advised by the RC of concerns or recommendations under either paragraph 6 or 8 of subsection (1).

Rationale and Summary
A RC member indicated that a response was not provided to recent concerns and recommendations that were shared.

The LEM and the ED confirmed that the home did not always respond to the concerns raised by the RC in writing, within 10 days.

Failing to respond in writing within 10 days of receiving the RC advice, may have contributed to residents in the home feeling as though their voices were not heard and that their concerns and recommendations would not be addressed by the home.

Sources: The minutes of RC and REC meetings; and interviews with residents, LEM, and ED.

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WRITTEN NOTIFICATION: General Requirements for Programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.

The licensee has failed to ensure that the general requirements for interdisciplinary programs required under s. 53. of O. Reg. 246/22, were complied with.

Specifically, that the Skin and Wound Care program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Rationale and Summary
The home's Skin and Wound Care program was not reviewed or revised in the last calendar year.

The DOC and ED both acknowledged that the program was required to be evaluated and updated annually, and was not.

When the home failed to ensure that the skin and wound care program was evaluated and updated at least annually in accordance with evidence-based practices, it placed the residents at risk of not receiving skin and wound care according to the most current best practices.

Sources: The home's policy titled, Skin and Wound Program; and interviews with the DOC and ED.

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WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring techniques when transferring residents.

Rationale and Summary
1) The plan of care for a resident identified that for transfers, the resident required a specific level of assistance, using a specific item.

A staff member documented that they had transferred the resident using a different level of assistance than what was identified in the resident's plan of care. Additional review of the documentation revealed that on other occasions, staff members had not transferred the resident as per their plan of care.

2) Another resident's transfer assessment indicated that the resident required a specific level of assistance. Review of the documentation for the resident revealed that staff members had not transferred the resident with the level of assistance required.

A staff member acknowledged that they had not transferred the residents as outlined in the plan of care.

Multiple staff members and the DOC all confirmed that staff members were required to follow a resident's plan of care specific to transfers; and when using a specific item, to always ensure that there

were two people present; that not doing so would not be safe.

Failing to ensure that staff members used safe transferring techniques when transferring residents may have resulted in significant injury to the residents.

Sources: Residents' clinical health records; the home's Zero Manual Lift/Safe Handling, Checklist and policy; and interviews with the DOC, ED, and other staff members.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #010 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 any standard or protocol issued by the Director with respect to infection prevention and control (IPAC) was implemented.

Rationale and Summary
According to s. 10.1 of the IPAC Standard for Long Term Care Homes (LTCHs), dated April 2022, the licensee was to ensure that the Hand Hygiene (HH) program contained access to HH agents, including 70-90 percent (%) Alcohol-Based Hand Rub (ABHR). The agents were required to be easily accessible at both point-of care and in other resident and common areas. Further to this, Public Health Ontario (PHO) Fact Sheet titled stated that expired product was not to be used.

Prior to a meal service, a staff member was observed distributing expired non-alcohol sanitizing wipes to residents for HH.

The IPAC Lead and DOC both confirmed that ABHR product expiry dates should always be checked prior to use, and that neither product should have been used for resident HH prior to meals, as they did not meet what was required in the IPAC standard.

Residents in the home were placed at risk of infection from pathogens on their hands, when the licensee failed to ensure that the HH agents in the home contained 70-90% alcohol, and were not expired.

Sources: Observations of a meal service; the home's policy titled, Handwashing and Hand Hygiene; the PHO Fact Sheet, selection and placement of ABHR during COVID-19 for Long-Term Care and Retirement homes; and interviews with the IPAC Lead, DOC, and other staff members.

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WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2)

The licensee has failed to ensure that their continuous quality improvement (CQI) committee was composed of at least the following persons:
1. The home's Administrator.
2. The home's Director of Nursing and Personal Care.
3. The home's Medical Director.
4. Every designated lead of the home.
5. The home's registered dietitian (RD).
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.
8. At least one employee of the licensee who has been hired as a PSW or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.
9. One member of the home's Residents' Council.
10. One member of the home's Family Council, if any.

Rationale and Summary
The home's CQI Committee Terms of Reference (TOR) confirmed that the membership did not include a member of the RC. Further to this, the membership of the committee did not include several other individuals required by the Act or Regulation.

The ED acknowledged that the membership of the CQI was not composed of those persons identified in the Act.

When the home's CQI Committee did not include all of the required members, there was a risk that the priorities for quality improvement would not be identified or accurately reflect the needs of those residents living in the home.

Sources: Review of Teck Pioneer CQI TOR; and interviews with a resident and the ED.

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WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (1)

The licensee has failed to prepare a report of the CQI initiative for the home for each fiscal year no later than three months after the end of the fiscal year.

Rationale and Summary
The home's website had no CQI initiative report posted.

The ED identified that the home did not prepare a report on the CQI initiative for the 2022-2023 fiscal year.

When the home did not prepare a CQI initiative report as required, residents and their families were not provided the opportunity to fully participate in the CQI Program and improvement of the quality of care, services, and accommodations.

Sources: Review of the home's website; and interviews with a resident, the ED, and other staff members.

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WRITTEN NOTIFICATION: Additional Training - Direct Care Staff

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (2) 1.

The licensee has failed to ensure that all staff who provided direct care to residents received annual training in all areas required under s. 82 (7) of the Act.

Rationale and Summary
O. Reg 246/22, s. 261 (1) 2. indicated that skin and wound care training for all staff who provided direct care to residents, was to be provided.

Several staff members indicated they had not received skin and wound training while working in the home. The home's educational records identified that the staff members were not assigned the course to complete. Further to this, not all direct care providers who were assigned the course, completed the annual training in skin and wound care.

The DOC and ED confirmed that annual training was required and should have been completed by all direct care staff.

Failing to ensure that staff were trained in skin and wound care on an annual basis, placed residents at risk of not having the most current and relevant approaches when receiving skin and wound care.

Sources: Review of the Surge learning course completion record; home's policy titled, Skin and Wound Care; and interviews with the DOC, ED, and other staff members.

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