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

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Original Public Report

Report Issue Date: March 13, 2024	
Inspection Number: 2024-1618-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: The Regional Municipality of Halton	
Long Term Care Home and City: Creek Way Village, Burlington	
Lead Inspector Lillian Akapong (741771)	**Inspector Digital Signature**
Additional Inspector(s) Stephanie Smith (740738)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 15, 16, 20, 21, 22, 23, 26, 27, 2024

The following intake(s) were inspected:

- Intake: #00108743 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Medication Management

Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

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)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that there was a written plan of care for two residents that set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary
A) A resident's care plan under the bathing activity of daily living (ADL), listed two different types of support: one person to provide some physical help and total assistance of one-two staff.

A staff member acknowledged that the resident's care plan may have been missed being updated and that the resident did not require total assistance for bathing. On a set date, the care plan was updated to reflect the resident's current level of required assistance.

B) Another resident's care plan and task list under the bathing ADL, listed two different bathing schedules.

One staff acknowledged that the resident's care plan also may have been missed being updated and that the staff were expected to follow the point of care (POC) task list. During the time of the inspection, the care plan was updated to refer staff to follow the POC task list for the bathing schedule.

Sources: Interviews staff, and residents care plans. [740738]

Date Remedy Implemented: February 23, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 265 (1) 10.
Posting of information
s. 265 (1) For the purposes of clause 85 (3) (s) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 85 of the Act includes the following:
10. The current version of the visitor policy made under section 267.

The licensee failed to ensure that the current version of the visitor policy was posted in the home.

Rationale and Summary
In accordance with section 85 (1) of the Fixing Long Term Care Act, 2021, every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements established by the regulations.

Specifically, during an initial tour of the home on a day in February, the home's current version of the visitor policy was not observed to be posted.

The Administrator acknowledged the current visitor policy was not posted. After discussion with the Administrator, the home's visitor policy was posted for all visitors to access.

Sources: Observations, interview with the Administrator. [740738]

Date Remedy Implemented: February 16, 2024

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided

to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan.

Rationale and Summary
On a set date, during the inspection, Inspector (740738) observed a resident between 1100 and 1500 hours. The resident required total assistance with their toileting activity of daily living (ADL) and wore briefs for incontinence. The resident's care plan stated that they were part of the check and change program. During the observation, the resident was not checked or changed.

A staff member acknowledged that the resident should have at least been checked to determine if they required a change during that time.

Failure to ensure that the care set out for a resident was provided as specified, put the resident at risk of altered skin integrity and/or discomfort.

Sources: Observations, residents' care plan, interviews with staff. [740738]

WRITTEN NOTIFICATION: Plan of care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's plan of care was revised when the resident care needs changed or care set out in the plan was no longer necessary.

Rationale and Summary
A resident's plan of care indicated that for their toileting ADL, staff were to attend at set scheduled time and use a transfer belt to perform the ADL.

One staff verified that this is not the current plan of care for the resident's toileting ADL and that they used a pivot transfer instead.

Failure to ensure that the plan of care was revised when the resident's care needs changed, put the resident at risk to be provided the wrong level of assistance with toileting.

Sources: Resident's care plan, interview with staff. [740738]

WRITTEN NOTIFICATION: Directives by Minister

NC #005 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 carry out every operational directive that applied to the long-term care home.

Specifically, per section 1.2 of the Minister’s Directive: COVID-19 response measures

for long-term care homes, the licensee was required to ensure that the masking requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, were followed.

Rationale and summary
The COVID-19 guidance document for long-term care homes (last updated November 7, 2023) required the licensee to ensure that all staff, students, volunteers, and support workers wore a medical mask in all resident areas.

One day in February, A staff was observed in a resident room with their mask below their chin. The resident was in the room and the staff was speaking to them.

Another day in February, the same staff was observed in the hallway with their mask below their chin. Inspector (740738) inquired why the staff's mask was below their chin. The staff responded that it is dry and they pull their mask down to cough and then proceeded to demonstrate this to the Inspector several times.

The Infection Prevention and Control (IPAC) Lead confirmed that the masking expectation is that staff wear masks when in all resident areas.

In addition to these two specific observations, multiple staff throughout the home were observed with their masks below their chins in resident areas.

Failure to ensure that the Minister's Directive was followed regarding masking, put the residents at risk for spread of infectious diseases.

Sources: Observations, interview with staff, COVID-19 guidance document for long-term care homes. [740738]

WRITTEN NOTIFICATION: Policies to be followed

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)
Policies, etc., to be followed, and records
s. 11 (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

The licensee has failed to ensure that the Skin and wound program's monthly meeting was complied as per policy.

The home's policy states that each home will have a Skin, Wound Care and Continence Care Resource Team that meets monthly to review individual resident skin, wound and continence issues, to discuss treatments and any ongoing educational needs. The team discusses current trends, complex skin, wound, and continence needs, examines the results of skin assessment tools used and ensures that care plans reflect resident specific strategies and interventions.
Specifically, during a record review, the meeting minutes for December 2023.

During an interaction with the skin and wound Lead, they stated that there was no time, so they did not meet in December.

By not meeting, staff did not receive education and update on strategies and intervention, which can have a negative impact on skin and wound care for the residents.

Sources: Skin and Wound Policy, interview with staff. [741771]

WRITTEN NOTIFICATION: Nutrition Manager

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 81 (4)
Nutrition manager
s. 81 (4) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (5), without including any hours spent fulfilling other responsibilities. O. Reg. 246/22, s. 81 (4).

The licensee has failed to ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection.

As per the legislative requirements, the minimum number of hours per week for the Nutritional Supervisor should 45.12 and their current hours are 35 hours. The Nutritional Supervisor stated that there is a float who visits the home every 2 weeks for 7 hours, those hours added does not meet the legislative requirements.

During an interview the Food and Nutrition Supervisor acknowledged that her hours and that of the float coverage did not meet the minimum legislative hours required by the legislative requirements.

Not meeting the required hours of work could have an impact on the resident's dietary needs and assessment.

Sources: Food Hydration and Nutrition Policy, interview with Nutrition Supervisor, Dietician, residents, Dietary staff. [741771]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #008 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 ensure that the IPAC Standard for Long-Term Care Homes, revised September 2023, was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, indicated under section 9.1 that Additional Precautions were to be followed in the IPAC program which included (f) additional personal protective equipment (PPE) requirements including appropriate selection, application, removal and disposal.

During observations on a day in February, there was contact precautions signage present for a resident's room. Two staff were observed exiting the room and were not wearing PPE. The contact precautions signage indicated that a gown, mask, and gloves were to be worn.

Inspector (740738) spoke to both staff and confirmed they were providing care to

the resident and that they did not wear PPE as the signage indicated. The staff did not have an answer as to why they were not wearing PPE and apologized to the Inspector.

Failure to wear the required PPE posed a risk of spreading infection to other residents.

Sources: Interview with staff, observations, IPAC Standard for Long-Term Care Homes revised September 2023. [740738]

WRITTEN NOTIFICATION: Quality

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee has failed to ensure that CQI Initiative report on their website, showed the dates when the results of the survey taken during the fiscal year were communicated to the residents and their families, Residents' Council, Family Council, and members of the staff of the home.

Rationale and Summary
A) A written annual Continuous Quality Improvement Interim Report 2022-2023 was posted to the home's website. The report did not include the dates when the results of the survey taken during the fiscal year were communicated to the residents and their families, Residents' Council, Family Council, and members of the staff of the home.

The Continuous Quality Improvement (CQI) Lead confirmed that the CQI report did not include the dates of the survey on the CQI report but stated the information was uploaded on Ontario health website.

Failing to document date of the survey results required under section 43 of the Act in the CQI reported posted to the home's website was a missed opportunity to ensure consistent distribution of the information to the residents and their families, Residents' Council, Family Council, and members of the staff of the home.

Rationale and Summary
B) A written annual Continuous Quality Improvement Interim Report 2022-2023 was posted to the home's website. The report did not include the date the survey was taken during the fiscal year.

The Continuous Quality Improvement (CQI) Lead confirmed that the CQI report did not include the dates of the survey on the CQI report but stated the information was uploaded on Ontario health website.

Failing to document date of the survey results required under section 43 of the Act in the CQI reported posted to the home's website was a missed opportunity to ensure consistent distribution of the information to the Public.

Sources: Home's website, Continuous Quality Improvement Report 2023, interview with Administrator. [741771]

WRITTEN NOTIFICATION: Orientation

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (c)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(c) signs and symptoms of infectious diseases;

The license has failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act included (c) signs and symptoms of infectious diseases.

Rationale and Summary
The home's education materials that were provided to staff on orientation and annually, did not include signs and symptoms of infectious diseases.

The IPAC Lead acknowledged that their education was missing this topic.

Sources: Education materials, interview with IPAC Lead. [740738]

WRITTEN NOTIFICATION: Orientation

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 259 (2) (d)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(d) respiratory etiquette;

The license has failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act included (d) respiratory etiquette.

Rationale and Summary
The home's education materials that were provided to staff on orientation and annually, did not include respiratory etiquette.

The IPAC Lead acknowledged that their education was missing this topic.

Sources: Education materials, interview with IPAC Lead. [740738]

WRITTEN NOTIFICATION: Orientation

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (e)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(e) what to do if experiencing symptoms of infectious disease;

The license has failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act included (e) what

to do if experiencing symptoms of infectious disease.

Rationale and Summary
The home's education materials that were provided to staff on orientation and annually, did not include what to do if experiencing symptoms of infectious disease.

The IPAC Lead acknowledged that their education was missing this topic.

Sources: Education materials, interview with IPAC Lead. [740738]

WRITTEN NOTIFICATION: Orientation

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 259 (2) (h)
Orientation
s. 259 (2) The licensee shall ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act includes,
(h) handling and disposing of biological and clinical waste including used personal protective equipment.

The license has failed to ensure that the training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act included (h) handling and disposing of biological and clinical waste including used personal protective equipment.

Rationale and Summary
The home's education materials that were provided to staff on orientation and annually, did not include the handling and disposing of biological and clinical waste including used personal protective equipment.

The IPAC Lead acknowledged that their education was missing this topic.

Sources: Education materials, interview with IPAC Lead. [740738]