Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 2, 2021	2021_899609_0007	007939-21, 010806-21, 012088-21	Critical Incident System

Licensee/Titulaire de permis

Board of Management for the District of Parry Sound West
21 Belvedere Avenue Parry Sound ON P2A 2A2

Long-Term Care Home/Foyer de soins de longue durée

Belvedere Heights
21 Belvedere Avenue Parry Sound ON P2A 2A2

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CHAD CAMPS (609)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 16-20, 2021.

The following intakes were inspected upon during this Critical Incident Inspection (CIS):

-One intake related to allegations of resident to resident abuse; and
-Two intakes related to allegations of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with residents, the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Services Manager (ESM), System Support Coordinator, Public Health Nurse (PHN), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping as well as Maintenance staff.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff and resident interactions, reviewed relevant health care records, internal investigation notes, training records, temperature logs, Human Resources (HR) files, as well as the home's relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

On July 14, 2021, the Chief Medical Officer of Health (CMOH) updated Directive #3 issued to the home, which required enhanced twice a day environmental cleaning and disinfection for frequently touched surfaces.

Housekeeping staff outlined a once a day process for disinfecting high touch surfaces in shared resident washrooms, which was verified by the home's cleaning instructions for housekeeping staff. Public Health staff indicated that high touch surfaces in the home's 42 shared washrooms required twice a day cleaning. The Environmental Services Manager (ESM) acknowledged that high touch surfaces in shared resident washrooms were disinfected once a day by staff.

High touch surfaces in shared resident washrooms being cleaned daily instead of twice a day presented minimal risk to residents.

Sources: CMOH Directive #3, COVID-19 Key Elements of Environmental Cleaning in Healthcare Settings document July 16, 2021, Day and Evening Cleaning Instructions for Housekeeping Staff, interviews with the Administrator, ESM, Housekeeping and Public Health staff. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents by ensuring twice a day cleaning of high touch shared washrooms, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by a staff member.

Physical abuse is defined within Ontario Regulation (O. Reg) 79/10 as, the use of physical force by anyone other than a resident that causes physical injury or pain.

a) A staff member of the home saw another staff member ignore a resident's right to be cared for in a manner consistent with their needs and caused unnecessary physical pain to the resident. The staff member also placed the resident's safety at risk by using improper transferring techniques.

b) A staff member of the home saw another staff member place a resident's safety at risk by using improper transferring techniques. The staff member verified that they did not immediately report the incident as the home's policy required. Had the staff member immediately reported the incident, the home would have been able to immediately initiate an investigation. The DOC verified that the staff member should have immediately reported the incident to the home.

c) The home was served a previous Compliance Order (CO) to ensure residents were not abused by a staff member.

Since then, the home has left residents unprotected from the staff member, with an additional six Critical Incident System (CIS) reports submitted to the Director outlining allegations of abuse of residents by the staff member, which the home substantiated no less than five additional times.

The home’s consistent failure to protect residents from the staff member presented actual harm to all the residents the staff member abused.

Sources: Surveillance footage, a resident's electronic clinical records, a resident’s Pain

Assessment, Compliance Smart Client (CSC) CIS reports submitted by the home, a staff member's Human Resources (HR) file, the home's policy titled "Prevention of Abuse and Neglect Zero Tolerance" Policy #PER-2300 last revised April 2021, interviews with the DOC and other staff. [s. 19. (1)]

2. The licensee has failed to ensure that a resident was protected from abuse by a staff member.

A staff member was overheard stating that they were going to provide care to a resident regardless of what the resident wanted. The staff member used improper positioning and transferring techniques and provided care to the resident that they did not want. Despite the incident being witnessed by other staff members, no one intervened to protect the resident. Other staff members acknowledged they should have intervened to protect the resident when the incident occurred as the home's policy required.

The home's failure to protect the resident from the staff member presented actual risk and pain to the resident.

Sources: The home's policy titled "Prevention of Abuse and Neglect Zero Tolerance" Policy #PER-2300 last revised April 2021, a CIS report, the home's internal investigation, a resident's electronic clinical records and plan of care, interviews with the DOC and other staff. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents of the home are protected from abuse by staff members, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the air temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home.

The ESM was unable to provide the Inspector with documentation of any air temperature measurements in resident bedrooms. Despite the home's heat related illness prevention plan which required the temperature be measured in at least two resident bedrooms, the ESM verified that the home was not measuring temperatures in resident bedrooms because it was "lots of work" for the maintenance staff.

The home's failure to ensure that air temperatures were measured and documented in at least two resident bedrooms in different areas of the home, presented minimal risk to residents.

Sources: Interviews with the Administrator, ESM, maintenance staff, Belvedere Heights Humidex Logs and the home's policy titled "Heat Related Illness Prevention Plan" policy #H&S-4058 last reviewed April 2021. [s. 21. (2) 1.]

2. The licensee has failed to ensure that the temperatures required to be measured were documented at least once every evening or night.

The ESM was unable to provide the Inspector with documentation of any air temperature measurements taken in the evenings or during the night. This was despite the home's heat related illness prevention plan, which required maintenance staff to measure temperatures once every evening or night after 1700 hours. The ESM verified that the home was not measuring temperatures during the evening or night because maintenance staff finished working at 1600 hours.

The home's failure to ensure that air temperatures were measured and documented at least once every evening or night presented minimal risk to residents.

Sources: Interviews with the ESM, maintenance staff, Belvedere Heights Humidex Logs and the home's policy titled "Heat Related Illness Prevention Plan" policy #H&S-4058 last reviewed April 2021. [s. 21. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the air temperature is measured and documented in writing in at least two resident bedrooms in different parts of the home and that the required temperatures are measured and documented at least once every evening or night, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that anyone who had reasonable grounds to suspect abuse of a resident or unlawful conduct by a staff member that resulted in risk of harm to a resident, immediately reported the suspicion to the Director.

Pursuant to the Long Term Care Homes Act (LTCHA) 2007, c. 8, s.152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A staff member saw another staff member use improper transferring techniques with a resident which was not reported to the Director.

The home’s failure to ensure that the staff member reported grounds to suspect abuse of a resident to the Director presented minimal risk of harm to the resident.

Sources: Surveillance footage, a CIS report, the home’s policy titled “Prevention of Abuse and Neglect Zero Tolerance” Policy #PER-2300 last revised April 2021, interviews with the DOC and other staff. [s. 24. (1)]

2. The licensee has failed to ensure that anyone who had reasonable grounds to suspect abuse of a resident, or unlawful conduct by a staff member that resulted in risk of harm to a resident, immediately reported the suspicion to the Director.

Staff members saw another staff member use improper positioning and transferring technique on a resident to provide care they did not want which was not immediately reported to the Director.

The home’s failure to ensure that staff members reported grounds to suspect abuse of a resident to the Director presented minimal risk of harm to the resident.

Sources: The home’s policy titled “Prevention of Abuse and Neglect Zero Tolerance” Policy #PER-2300 last revised April 2021, CIS report #M503-000014-21, the home’s internal investigation and interviews with the PSW #115, RPN #108 and the DOC. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that anyone who has reasonable grounds to suspect abuse of residents, or unlawful conduct by a staff that resulted in risk of harm to residents, immediately reports the suspicion to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program.

The Inspector saw one meal service on each of the home's three units, where some staff would provide hand hygiene (HH) to residents before and after their meals while others did not. Multiple residents came to the dining room with no HH provided or encouraged before the residents began their meals. Staff members admitted that residents should have their hands cleaned before and after meals and that they sometimes forgot. The Administrator verified that residents should have been encouraged to clean their hands prior to and after meals as outlined by the home's policy which was based on the Just Clean Your Hands (JCYH) program.

The home's failure to ensure that staff provided and/or encouraged HH to residents before and after their meals presented minimal risk of harm.

Sources: Inspector's three meal service observations, the home's policy titled "Hand Hygiene & Care Program" policy #IPC: G 40.00 effective November 2016, the "Just Clean Your Hands Implementation Guide Ontario's step-by-step guide to implementing a hand hygiene program in your long-term care home" evidenced-based document, interviews the Administrator and other staff. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the IPAC program by ensuring residents are provided and/or encouraged with HH before and after meals, to be implemented voluntarily.

Issued on this 23rd day of September, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.