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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: May 24, 2024

Inspection Number: 2024-1149-0001

Inspection Type:
Critical Incident

Licensee: Blackadar Continuing Care Centre Inc.

Long Term Care Home and City: Blackadar Continuing Care Centre, Dundas

Lead Inspector	**Inspector Digital Signature**
Emma Volpatti (740883)	Emma Volpatti Digitally signed by Emma Volpatti Date: 2024.05.28 16:07:25 -04'00'

Additional Inspector(s)
Stephanie Smith (740738)
Rebecca Lepore (000781) was an observer during this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 8-10, 13-15, 2024

The following intake(s) were inspected:

- Intake #00102295 [Critical Incident (CI) #2641-000043-23] - related to the prevention of abuse and neglect.
- Intake #00102711 [CI #2641-000044-23] - related to the prevention of abuse and neglect.
- Intake #00103969 [CI #2641-000047-23] - related to falls prevention and management.
- Intake #00105918 [CI #2641-000001-24] - related to infection prevention and control.

- Intake #00109880 [CI #2641-000004-24] - related to protection from certain restraining.

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

Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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

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 the written plan of care for a resident provided clear directions to staff and others who provide direct care to the resident.

Rationale and Summary

A resident returned to the home from the hospital with a skin alteration. Review of their plan of care indicated there was an order for an intervention once daily as needed but did not specify what the exact intervention was.

The Director of Care (DOC) acknowledged that the order did not provide clear direction to staff.

Failing to provide clear direction to staff posed a risk of improper wound treatment.

Sources: A resident's clinical record, interview with the DOC. **[740883]**

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee has failed to ensure that the provision of care set out in the plan of care was documented for a resident.

Rationale and Summary
A resident's plan of care indicated they were to have a specific intervention in place.

The resident sustained a fall with injury. Review of the documentation for that day indicated that the specified intervention was not documented as completed during the day.

The DOC acknowledged that the staff did not document that the intervention was completed.

Sources: A resident's clinical record, interview with the DOC. **[740883]**

WRITTEN NOTIFICATION: Policy to Minimize Restraining of Residents, etc.

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 33 (1) (b)
Policy to minimize restraining of residents, etc.
s. 33 (1) Every licensee of a long-term care home,
(b) shall ensure that the policy is complied with.

The licensee has failed to ensure that the written policy to minimize the restraining of residents was complied with.

Rationale and Summary
A resident was restrained in their bed using specific items. There was no documentation of this restraint being applied and no assessments to use the restraint.

The DOC acknowledged that the items restricted the resident's freedom of movement and that the staff did not follow the home's least restraint policy.

Failure to ensure that the home's least restraint policy was complied with put a resident's safety and well-being at risk.

Sources: CI report, the home's investigation notes, the home's policies, interviews with staff and the DOC. **[740738]**

WRITTEN NOTIFICATION: Protection from Certain Restraining

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 34 (1) 1.

Protection from certain restraining
s. 34 (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff.

The licensee has failed to ensure that a resident was not restrained, in any way, for the convenience of the staff.

Rationale and Summary
The home filed a CI report with the Ministry of Long-Term Care (MLTC) that a resident had been restrained in their bed using specified items.

A direct care staff and the Administrator verified that staff did this to prevent the resident from falling or climbing out of their bed. The resident had falls prevention interventions in place at the time of the incident.

Failure to ensure that a resident was not restrained, in any way, put the resident's safety and well-being at risk.

Sources: A resident's plan of care, CI report, interviews with staff. **[740738]**

WRITTEN NOTIFICATION: Responsive Behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 1.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

The licensee has failed to ensure that a resident's behavioural triggers were identified in their care plan.

Rationale and Summary
A resident had responsive behaviours. Their care plan did not identify triggers to their responsive behaviours.

The home's policy indicated that triggers to a resident's behaviours should be identified in their care plan. A direct care staff stated that the resident's behavioural triggers were not identified anywhere within the resident's plan of care.

Sources: A resident's clinical records, the home's policy, interviews with staff.
[740738]

WRITTEN NOTIFICATION: Housekeeping

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The licensee has failed to ensure that procedures were developed and implemented for cleaning and disinfection of contact surfaces.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure that

procedures are developed and implemented for cleaning and disinfection of contact surfaces.

Specifically, staff did not comply with the their policy which was included in the home's housekeeping program.

Rationale and Summary
A housekeeper was observed cleaning a resident room that was under additional precautions. They were observed mopping and dusting the floors, emptying the garbage and cleaning the bathroom. No high touch surfaces were observed to be cleaned in the room.

The home's policy indicated that the housekeeper is to clean high touch surfaces with a disinfectant and cloth such as door handles, light switches, call bells and cords, bed controls and TV remotes.

The Infection Prevention and Control (IPAC) Manager acknowledged that the high touch surfaces should have been cleaned.

Sources: Interview with the IPAC Manager, observations in the home, the home's policy. **[740883]**

COMPLIANCE ORDER CO #001 Communication and Response System

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

- Ensure that all direct care staff have access to and carry with them during their shifts, a working pager as part of the home's communication and response system

Grounds

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed, and used by residents, staff and visitors at all times.

Rationale and Summary
The home's resident-staff communication and response system included a marquee in the hallway (on second and third floors) and pagers that staff carry. The marquee faced east in the hallways and was not visible from the nursing station or dining room.

On an identified date, it was observed that the marquee was displaying incorrect information. Upon follow-up with staff, they informed Inspectors that they carry pagers to be notified when a call bell is activated. When on the second floor, staff were unable to show Inspectors these pagers as they did not have any available to use that day. The following day, staff informed Inspectors that they had one pager for the three direct care staff working on the floor at the time.

Two staff indicated that staff will mistakenly take pagers home which would leave the floor without pagers to use. The Administrator indicated that several pagers

were broken and recently sent for repairs, leaving the home with one working pager on each floor.

Failure to ensure that the resident-staff communication and response system was easily seen, accessed, and used by staff, put resident's' safety at risk.

Sources: Observations, interviews with staff and the Administrator. **[740738]**

This order must be complied with by: July 4, 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

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.