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 West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: April 8, 2024
Original Report Issue Date: March 20, 2024
Inspection Number: 2024-1279-0002 (A1)
Inspection Type: Proactive Compliance Inspection
Licensee: MacGowan Nursing Homes Ltd.
Long Term Care Home and City: Braemar Retirement Centre, Wingham

Amended By Kaitlyn Puklicz (000685)	**Inspector who Amended Digital Signature** Kaitlyn Joan Puklicz Digitally signed by Kaitlyn Joan Puklicz Date: 2024.04.19 09:00:23 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Remove non-compliance #009 related to O. Reg. 246/22, s. 166 (2) 7.

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Lead Inspector Kaitlyn Puklicz (000685)	**Additional Inspector(s)** Nuzhat Uddin (532)
Amended By Kaitlyn Puklicz (000685)	**Inspector who Amended Digital Signature** Kaitlyn Joan Puklicz Digitally signed by Kaitlyn Joan Puklicz Date: 2024.04.19 09:00:45 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Remove non-compliance #009 related to O. Reg. 246/22, s. 166 (2) 7.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 4 - 8, 11 - 12, 2024

The following intake(s) were inspected:

- Intake: #00110295 - Proactive Compliance Inspection

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
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

AMENDED 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 (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 failed to ensure that a resident was reassessed and their plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

A PSW stated that the resident's plan of care was not up to date as there were portions of their care plan that no longer applied due to a change in the resident's health condition.

The resident was placed at risk when their plan of care was not reviewed and revised after their care needs had changed.

Sources: plan of care for the resident, observations, interview with the resident, their substitute decision maker, the DOC and the PSW.

[532]

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)
Resident and Family/Caregiver Experience Survey
s. 43 (4) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in carrying out the survey and in acting on its results.

The licensee has failed to seek the advice of the Residents' Council in carrying out the survey and in acting on its results.

The Residents' Council meeting minutes from October to December 2023 showed no documentation to support that the council was involved in carrying out the survey.
A member of the Residents' Council did not recall being involved in the development of the satisfaction survey, nor the opportunity to provide feedback

about the survey.

The Professional Practice and Resident Care Coordinator (RCC) confirmed that the Residents' Council was not consulted in the development of the survey, nor given the opportunity to provide feedback, prior to the release of the resident satisfaction survey in December 2023.

Sources: Residents' Council meeting minutes from October to December 2023, interview with a Residents' Council member and the RCC.

[000685]

WRITTEN NOTIFICATION: Duty of licensee to consult Councils

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 73
Duty of licensee to consult Councils
s. 73. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months.

The licensee has failed to ensure that they consulted regularly with the Residents' and Family Council, at least every three months.

During a record review of resident and family council meeting minutes, there was no documentation that indicated the licensee had consulted with the residents' or family council.
A member of the Family Council stated that the licensee had not consulted with the council.

The RCC confirmed that the licensee does not consult every three months with the Residents' and Family Councils at this time.

Sources: Meeting minutes for resident and family councils, interview with a member of the Family Council and the RCC.

[000685]

WRITTEN NOTIFICATION: Doors in a home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

A) During observations, the rope used to deter resident entry to the service hall was left down, and the laundry room doors, kitchen door and maintenance room doors in this hallway were found to be left open or unlocked, with no staff present. During observations the following day, the service hallway rope was noted to be down

again when no staff were present and one of the laundry room doors was unlocked and unsupervised. No staff were present inside the room or in the environmental hallway that was not blocked off by the rope at that time.

The home did not have a policy in place regarding door safety within the home at the time of these observations.

The DOC stated residents should not have access to an electrical room, laundry room or kitchen.

Sources: Observations, the home's policy, interview with the DOC.

[000685]

B) During observations over the course of three days, an unmarked electrical/battery room was found unlocked and unsupervised. The inside of the room contained a sign that said "lift battery charging station" and there were multiple batteries seen plugged into the wall. There was also a fuse box with the door open.

The home did not have a policy in place regarding door safety within the home at the time of these observations.

The RCC stated as a practice, the battery room door should always be locked. They also stated that ensuring this door is locked when not in use is the expectation and is communicated to all staff.

Residents' were placed at risk when there was unsupervised and unrestricted door access to non-residential areas.

Sources: observations, interview with the the RCC.

[000685]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration;

The licensee has failed to ensure that the nutritional care and dietary services program was implemented.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that there was an organized program of nutritional care and dietary services which included the implementation of policies relating to nutritional care and dietary services and hydration, that must be complied with.

A) The home's "Pleasurable Dining with Dignity" policy, last reviewed November

2023, stated that the order of meal service was to be rotated so that all residents have an opportunity to be served first and that the service order was available in the dining room for staff reference.

During a meal service observation, it was noted that there was no table rotation schedule posted and the last table was served close to 1257 hours.

A dietary aide stated that they always follow the same table rotation starting from table number three.

A resident indicated that the table rotation was always the same and that they were served second last every time. They also said they have to wait over 45 minutes to get their meal, that the weekends are worse due to a staffing shortage and that it would be nice to be first sometimes.

Both the Registered Dietician (RD) and the nutrition manager (NM) acknowledged that the table rotation was not happening and is an area that the home needs to improve on.

The residents' meal experience may have been negatively impacted when staff did not follow a table rotation leading to an unfair distribution of the residents' meals.

Sources: Observations, the home's Pleasurable Dining with Dignity policy, last reviewed November 2023, interviews with a resident, a dietary staff, the RD and the NM.

B) The home's policy, Production of Texture of Modified Food and Thickened Fluids, dated January 2024, stated the objective is to ensure that the menu item choices for residents who require texture modified foods follow the choices provided on the

regular menu as closely as possible. It stated to ensure that all texture modified foods were safe and were produced in a manner that follows HCCAP principles and that foods that were soft or were prepared from minced meats (e.g., shepherds pie, meatloaf, macaroni, and cheese,) may be acceptable (as determined by the Registered Dietitian) "as is" for minced diets without requiring further manipulation.

A resident was on a texture modified diet.

During a meal service observation, it was identified that the resident did not receive their meal as per their special diet requirements.

The RD acknowledged that specific items in the main course should have been a different texture as indicated on the menu.

Failing to follow the production of a texture modified diet that met the resident's needs placed them at risk of not being able to digest their meal.

Sources: Observations, the home's policy Production of Texture of Modified Food and Thickened Fluids, dated January 2024, interview with a resident and the RD.

[532]

WRITTEN NOTIFICATION: Infection prevention and control

NC #006 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).

As outlined in the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, the licensee has failed to ensure that when a resident is placed on additional precautions, point of care signage indicating the IPAC control measures and Personal Protective Equipment (PPE) requirements are posted.

During an observation, the Inspector noted that a resident's room had signage posted outside their door regarding donning and doffing PPE, as well as directions for applying hand sanitizer. The Inspector noted the signage indicating the type of additional precaution they required was not posted in a visible place. Instead the additional precaution sign was found tucked behind the donning PPE sign, fully hidden from view. The Inspector spoke with a PSW to inquire about the resident's isolation status and why the sign was hidden. The PSW removed the additional precaution sign to look at it, confirmed the resident required additional precautions, then placed the sign back where it had been instead of placing it where staff and visitors could see it.

The following day, the same resident's room was observed again and this time there was no signage on or near the door. The donning/doffing and hand rub signs were gone, and there was no additional precaution signage posted.

The home's policy, Additional Precautions, revised January 2023, stated that staff must ensure there is appropriate signage specifying the precautions needed.

The IPAC lead confirmed that the resident required additional precautions and that a sign should be posted outside of their room.

Sources: Infection prevention and control (IPAC) Standard for Long-Term care

Homes, revised September 2023, observations, the home's Additional Precautions policy, revised January 2023, interview with a PSW and the IPAC lead.

[000685]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that all staff participated in the home's Infection Prevention and Control (IPAC) Program.

During an observation, numerous staff members were seen assisting residents into the dining room for lunch. At least ten residents were assisted into the dining room by staff and not offered or provided hand hygiene prior to eating their meal. At least six other residents entered the dining room independently and no hand sanitizer was offered or provided to them prior to eating their meal. Of note, no hand sanitizers were observed on any of the tables in the dining room.
During observations the following day, numerous staff members were seen assisting residents into the dining room for lunch. Only one staff member was observed assisting certain residents with hand hygiene. The rest of the staff did not

offer or assist residents' with hand hygiene prior to eating their meal.

The home's policy, Resident and Visitor Hand Hygiene, revised June 2022, stated that hand hygiene should be encouraged for residents' before eating and drinking.

The IPAC lead confirmed that staff are to assist residents with hand hygiene prior to and after meals.

Sources: Observations, the home's policy, Resident and Visitor Hand Hygiene, revised June 2022, interview with the IPAC lead.

[000685]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 7.
This non-compliance has been rescinded.

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at

least the following persons:
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee has failed to ensure that the home's continuous quality improvement (CQI) committee was composed of the following mandatory member: an employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The DOC confirmed that the home's CQI committee does not currently include a PSW.

Sources: Quality council meeting minutes Q1 (January-March 2023), interview with the home's DOC.

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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) 9.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:

9. One member of the home's Residents' Council.

The licensee has failed to ensure that the home's continuous quality improvement (CQI) committee was composed of the following mandatory member: one member of the home's Residents' Council.

The DOC confirmed that the home's CQI committee does not currently include a member of the Residents' Council.

Sources: Quality council meeting minutes Q1 (January-March 2023), interview with the home's DOC.

[000685]

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 10.
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
10. One member of the home's Family Council, if any.

The licensee has failed to ensure that the home's continuous quality improvement (CQI) committee was composed of the following mandatory member: one member of the home's Family Council.

The DOC confirmed that the home's CQI committee does not currently include a

member of the Family Council.

Sources: Quality council meeting minutes Q1 (January-March 2023), interview with the home's DOC.

[000685]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 1.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
1. The name and position of the designated lead for the continuous quality improvement initiative.

The licensee has failed to ensure that the name and designation of the home's Continuous Quality Improvement (CQI) lead was included in their most recent report.

During review of the home's CQI report for the 2022-2023 fiscal year, there was no mention of the home's CQI lead.

The DOC confirmed that they are the CQI lead for the home and the home's CQI report does not include this required component.
Sources: the home's CQI Annual Plan 2023, interview with the DOC.

[000685]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 3.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
3. A written description of the process used to identify the home's priority areas for quality improvement for the next fiscal year and how the home's priority areas for quality improvement for the next fiscal year are based on the recommendations of the home's continuous quality improvement committee.

The licensee has failed to ensure that the home's CQI report contained a written description of the process used to identify the home's priority areas for quality improvement for the next fiscal year and how the home's priority areas for quality improvement for the next fiscal year are based on the recommendations of the home's continuous quality improvement committee.

The home's CQI report for the 2022-2023 fiscal year was reviewed and noted to be missing the required written description.

The DOC confirmed that this written process was not described in the report as required.

Sources: the home's CQI Annual Plan 2023, interview with the DOC.

[000685]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
5. A written record of,
i. the date the survey required under section 43 of the Act was taken during the fiscal year,
ii. the results of the survey taken during the fiscal year under section 43 of the Act, and
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 the home's CQI report for the 2022-2023 fiscal year contained the date the survey required under section 43 of the Act was taken during the fiscal year, the results of the survey, and how and when the results of the survey were communicated to the residents and their families, Residents' Council, Family Council, and members of the staff of the home.

The home's CQI report for the 2022-2023 fiscal year was reviewed and noted to be missing all the required information about the home's Resident and Caregiver Experience surveys.

The DOC stated the report does not include the date the surveys were taken, the results of these surveys, and how and when the results were communicated to

residents and their families, Residents' Council, Family Council, and members of the staff of the home.

Sources: the home's CQI Annual Plan 2023, interview with the DOC.

[000685]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee has failed to ensure that a copy of the CQI report was provided to the Residents' Council.

During record review of the Residents' Council meeting minutes, there was no documentation to support that the Residents' Council was provided a copy of the home's CQI report.

The Professional Practice and Resident Care Coordinator (RCC) stated the CQI report was not shared with the Residents' Council.

Sources: Residents' Council meeting minutes, interview with the RCC.

[000685]