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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 11, 2022	2022_868561_0002	019710-21	Complaint

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

Burloak
5959 New Street Burlington ON L7L 6W5

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

DARIA TRZOS (561), BARBARA GROHMANN (720920)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 23, 24, 25, 28, March 1, 2, 3, 4, 7, 9, 10, 2022.

This Complaint (CO) inspection with a log #019710-21 was related to nutrition, personal care concerns, continence care and insufficient staffing.

A Critical Incident (CI) inspection #2022_868561_0001, was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Interim Director of Care (DOC), Assistant Director of Care (ADOC), Registered Dietitian (RD), Resident Assessment Instrument (RAI) Cooridnator, Ward Clerk, Registered Nursing staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), housekeeping staff family member and residents.

During the course of the inspection, the inspector(s): toured the home, completed an Infection Prevention and Control (IPAC) assessment, observed provision of care, reviewed the complaints records, reviewed clinical records and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 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 failed to ensure that all staff participated in the implementation of the IPAC program related to hand hygiene, donning and doffing of Personal Protective Equipment (PPE), additional precautions practices and availability of PPE.

A) The licensee failed to ensure that all staff participated in the implementation of the IPAC program related to resident hand hygiene.

The JCYH Long-Term Care Home (LTCH) Implementation Guide specified that "residents' hands must be cleaned before and after meals". The home's policy Routine Practices and Additional Precautions stated that "proper hand hygiene will be promoted by all residents, employees, and visitor to minimize the risk of spreading infection".

i. On February 23, 2022, at lunch, PSWs were observed providing hand sanitizer to five of the 21 residents in the dining room prior to receiving their meal. No residents were provided with hand sanitizer when the meal concluded.

ii. On February 24, 2022, at 1420 hours, snack pass was observed. A PSW did not provide or assist residents with hand hygiene prior to receiving their snacks. The PSW acknowledged that there was an expectation to sanitize residents' hands prior to providing snacks.

iii. On February 28, 2022, at lunch, PSWs were observed cleaning residents' hands with wipes prior to providing their meal. Hand hygiene was not offered or performed after the meal concluded.

The interim DOC confirmed the home was following Just Clean Your Hands (JCYH) for hand hygiene. They expected that residents would be assisted with hand hygiene before and after meals and snacks.

Failure to perform hand hygiene for residents or encourage hand hygiene before and after meals or snacks, may have increased the risk of spreading infectious organisms.

Sources: observations; Routine Practices and Additional Precautions (IPC2-P10, March 31, 2021), JCYH LTCH Implementation Guide; and interviews with interim DOC and other staff.

B) The licensee failed to ensure that all staff participated in the implementation of the IPAC program related to donning and doffing.

The home’s policy titled "Routine Practices and Additional Precautions", stated that “all employees will follow routine practices and additional precautions” and “employees will be trained on the use of Personal Protective Equipment (PPE) to minimize exposure to infectious diseases”. The home's procedure titled "Contact Precautions", stated that staff were required to wear gowns and gloves when entering a resident's room with contact precautions.

The interim DOC explained that infographics were used to educate the staff on the correct order for donning and doffing and a sign was posted to remind staff of the correct order. The PPE sign and infographic showed that staff were to don a gown before their gloves and doff gloves before their gown.

A PSW was observed entering a resident's room that had a contact precautions sign on the door. The PSW donned gloves before their gown and doffed their gown before their gloves, which did not follow the order indicated in PPE signs or infographics. The PSW confirmed that the resident was on contact precautions and that they needed to follow the correct order to don and doff PPE.

Failure to don and doff PPE according to the established process may have increased the risk of spreading infectious organisms to residents and/or other staff.

Sources: observations; Routine Practices and Additional Precautions (IPC2-P10, March 31, 2021), PPE Sign, Contact Precautions (IPC2-010.06, March 31, 2021), Infographics: Putting it On in 5 Easy Steps and Taking it Off in 6 Easy Steps; and interviews with interim DOC and other staff.

C) The licensee failed to ensure that all staff participated in the implementation of the IPAC program related to additional precautions.

The home’s policy titled "Routine Practices and Additional Precautions" stated that “all employees with follow routine practices and additional precautions”. The home’s procedure titled "Contact Precautions and Droplet Precautions" stated that contact precautions or droplet precautions signage was to be visible on entry to a resident’s room.

Several rooms were observed to have a hanging PPE caddy on the doors; however, there was no signage to communicate the type of precautions required on all these

doors.

A RPN confirmed that appropriate signage should have been posted on the doors to indicate which additional precautions the residents were on.

The interim DOC confirmed that there was an expectation that rooms that have residents on additional precautions needed to have the appropriate signage posted to alert the staff what PPE to wear when entering these rooms.

Failure to provide clear visual communication regarding resident's isolation requirements presented a risk should staff not be aware of the care needs of residents and not take precautions as required.

Sources: observations; Routine Practices and Additional Precautions (IPC2-P10, March 31, 2021), Contact Precautions (IPC2-010.06, March 31, 2021), Droplet Precautions (IPC 2-010.07, March 31, 2021); and interviews with interim DOC and other staff.

D) The licensee failed to ensure that all staff participated in the implementation of the IPAC program related to availability of PPE.

The home’s procedures on Droplet Precautions and Contact Precautions clearly identified what PPE should be available at point of care.

i. Observations were made in Breckon House and residents in two rooms were on contact and cytotoxic precautions; however, there were no hanging PPE caddies on the doors.
A resident in another room was on contact precautions; however, there were no gowns available in the hanging PPE caddy on the door.

ii. Observations were made in Breckon House and one resident was on droplet precautions; however, there was no eye protection in the hanging PPE caddy on the door.

iii. Observations were made in Zimmerman House and one resident was on droplet precautions; however, there were no eye protection or gowns in the hanging PPE caddy on the door.

A RPN confirmed that for a resident on droplet precautions, eye protection would be

available to the staff.

The interim DOC stated that gowns, masks, gloves, and face shields were to be readily available in the home and confirmed that for residents on droplet precautions, face shields should have been available in the PPE caddies.

Failure to have the appropriate PPE readily available at the point of care presented a risk of staff entering a resident's room without access to the required PPE.

Sources: observations; Routine Practices and Additional Precautions (IPC2-P10, March 31, 2021), Contact Precautions (IPC2-010.06, March 31, 2021), Droplet Precautions (IPC 2-010.07, March 31, 2021); and interviews with interim DOC 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 all staff participate in the implementation of the infection prevention and control (IPAC) program, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for a resident provided clear direction to the staff regarding the care and maintenance of the resident's feeding device.

A resident required a device for feeding to meet all their nutritional and hydration needs and they were on a specific daily schedule.

In the resident's written plan of care, staff were to refer to the electronic Medication Administration Record (eMAR)/electronic Treatment Administration Record (eTAR) for an order related to the management of resident's device. The resident's current physician orders, eMAR and eTAR, did not include an order for or clear direction regarding the management of their device. Staff were to refer to eMAR for medications used for the management of it. The resident's current physician orders and eMAR did not include an order for medication to be used for the management of the device or clear direction on how to manage it.

The ADOC stated that specific nursing information was not in the written plan of care but directed staff to refer to the eMAR instead. The ED confirmed that based on the resident's written plan of care, it was expected that nursing staff would refer to the eMAR for direction.

Failure to ensure that the written plan of care provided clear direction related to the resident's feeding device and maintenance and management of it had the potential for the resident not to receive care in accordance with their needs.

Sources: review of resident's written plan of care, eMAR and eTAR; interviews with ED and other staff. (720920) [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care for a resident was revised when the resident's care needs changed, regarding a grooming plan agreed to by the resident's substitute decision maker (SDM).

The DOC initiated a client services response form (CSR) in response to a complaint from a resident's SDM. The complaint focused on the resident's care, specifically grooming. A plan was created related to the grooming needs for the resident and the CSR was signed by both the DOC and ED, documented the plan along with the communication to the staff.

The resident's written plan of care was not updated to include the grooming plan as outlined in the CSR. No documentation regarding the grooming plan was found in the progress notes, Kardex and/or task lists.

RAI Coordinator stated that they were unaware of the grooming plan and stated that the written plan of care should have been updated, along with a progress note documenting the information. A PSW was unaware of the new grooming plan.

The ED was aware of the complaint and expected that the plan of care would be updated to reflect the change to the resident's care needs.

Failure to revise the plan of care had the potential for the resident not to receive care in accordance with their needs.

Sources: resident's written plan of care, progress notes and tasks; Client Services Response Form; observations; and interviews with ED and other staff. (720920). [s. 6. (10) (b)]

Issued on this 20th day of April, 2022

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

Original report signed by the inspector.