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: July 29, 2024
Inspection Number: 2024-1127-0002
Inspection Type: Critical Incident
Licensee: DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC II Long Term Care GP Inc. and Arch Venture Holdings Inc.
Long Term Care Home and City: Niagara Long Term Care Residence, Niagara On The Lake

Lead Inspector	**Inspector Digital Signature**
Jonathan Conti (740882)	Jonathan Conti Digitally signed by Jonathan Conti Date: 2024.08.26 14:00:35 -04'00'

Additional Inspector(s)
Meghan Redfearn (000765)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 9-12, July 15-19, 2024.

The following intakes were inspected:

- Intake: #00112250/Critical Incident (CI) #2618-000008-24 was related to infection prevention and control.
- Intake: #00110543/CI #2816-000005-24 was related to an injury to resident of unknown cause.
- Intake: #00112150/CI #2618-000007-24 was related to falls prevention and management; and
- Intake: #00114392/CI #2618-000012-24 was related to prevention of abuse and neglect.

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

The following intakes were completed in this inspection:
Intake: #00109066/CI #2618-000002-24; Intake #00112806/CI #2618-000010-24 were related to infection prevention and control.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
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 (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 care set out in the plan of care for a resident was provided to them as specified in their plan.

Rationale and Summary

A resident's care plan indicated they were required to have a specific intervention in place at an identified time. On two observed dates, the resident's specific intervention was not in place at the identified times. It was brought to staff's attention and staff were observed reapplying the intervention on those dates.

Staff acknowledged they had reapplied the intervention and another staff identified the intervention was removed during care and this it may not have been reapplied afterwards..

Observations were made on additional dates and the resident was observed sitting in at identified times with the specified intervention in place.

Sources: Resident plan of care; observations of resident in wheelchair; interviews with the DOC and other staff.

Date Remedy Implemented: July 10, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)

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.

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

Rationale and Summary
As last updated in a resident's plan of care at a specified date in January 2024, the resident required a specified intervention to prevent risk of altercation with other residents.

Staff acknowledged that the intervention was not being utilized as it was no longer necessary since the resident moved to a different home area at a specified date. Staff confirmed the intervention was still listed in the plan of care but was no longer required due to other more effective interventions in place.

On July 16, 2024, registered staff reassessed and updated interventions for the resident to remove the specified intervention.

Sources: Observations of a resident; interviews with staff; resident clinical records including care plan and progress notes.

Date Remedy Implemented: July 16, 2024

WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The licensee failed to ensure that resident #001 was protected from physical abuse by resident #002.

As per O. Reg. 246/22, s. 2(1), "physical abuse" from resident to resident is defined as the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitements d'ordre physique").

Rationale and Summary
On a specified date, resident #002 was being monitored following a medication change, and was observed by staff to be agitated with pacing and wandering around the unit. At a specified time, there was an altercation initiated by resident #002 with resident #001, which required staff to separate both residents and assess for pain and injury.

Resident #001 received a head-to-toe assessment in which there was a specific injury noted. Internal investigation notes confirmed this injury. Follow up assessments completed the following days identified that resident #001 sustained an additional injury as a result of the altercation.

The Assistant Director of Care (ADOC) and Director of Care (DOC) both acknowledged that resident #001 had physical injuries related to the physical force used by resident #002. Staff confirmed that further intervention and 1:1 monitoring for resident #002 was put into place following the incident to prevent further risk of abuse to other residents.

Failure to protect resident #001 from physical abuse by resident #002 caused physical injury and presented a risk to resident #001's safety.

Sources: Resident #001 and resident #002 clinical records including progress notes, care plan, assessments, skin and wound assessments; CI Report; internal investigation notes; interviews with DOC and other staff.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure immediate reporting to the Director of the physical abuse of resident #001 that resulted in injury.

Rationale and Summary
At an identified time on an identified date in April 2024, an altercation occurred between resident #001 and resident #002, resulting in an injury to resident #001. The registered staff that intervened and separated the two residents confirmed they did not call the after-hours line nor the manager on call to report the physical abuse witnessed.

After being informed about the incident by another registered staff member the following day, the manager on call submitted an after-hours report.

The ADOC and DOC acknowledged that the incident was not immediately reported to the Director through the after-hours phone number and should have been reported by the registered staff who witnessed the incident.

Sources: Interviews with ADOC, DOC, and other staff; progress notes for resident #001 and resident #002; the home's internal investigation notes; Critical Incident report; InfoLine report; nursing resource binder.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident from their bed to their wheelchair.

Rationale and Summary
A resident's care plan indicated that they were to be transferred using specified physical assistance with a mechanical lift. During an investigation, the home determined that on an identified date, a staff member had physically transferred the resident by themselves from their bed to their wheelchair.

The staff member stated that they did not use the mechanical lift to transfer the resident, and physically picked the resident up on their own for the transfer. The staff member acknowledged the resident required a mechanical lift for transfers and that it was a mistake not using the lift. The DOC acknowledged that the staff member did not use safe transfer and positioning techniques when transferring the resident from their bed to their wheelchair.

There was a risk of injury to the resident when staff did not use the mechanical lift during a transfer.

Sources: Resident care plan; investigation notes; interviews with the DOC and PSW #110.

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

The licensee failed to ensure that a resident received a skin assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment after they exhibited altered skin integrity.

Specifically, a resident did not receive a new altered skin integrity assessment when a newly identified skin breakdown occurred on a specified date.

Rationale and Summary
After an altercation between two residents on a specified date, one resident sustained an injury in the form of a skin breakdown. The home's internal investigation notes further confirmed the injury. The skin breakdown was noted by a

registered staff member when the resident was assessed after the altercation, however no clinically appropriate assessment was completed using the home's Wound Round assessment.

The DOC and registered staff confirmed that any new altered skin integrity, including the identified skin breakdown for the resident, had required an initial Wound Round assessment, and that this process was not followed as per the home's skin care and wound management program.

There was a posed risk that the resident's newly identified skin breakdown was not properly assessed when registered staff failed to use the home's clinically appropriate tool.

Sources: Interview with registered staff, ADOC, and DOC; resident clinical record including progress notes, assessments; the home's Skin Care and Wound Management program.

WRITTEN NOTIFICATION: Administration of drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that a drug for a resident was administered in accordance with the directions specified for use by the prescriber.

Rationale and Summary
On a specified date, a resident was reassessed by the nurse practitioner for pain and behaviour management, and a specified drug was increased to twice daily for the resident.

On a later date, registered staff identified during the second medication pass that the staff earlier in the day missed administration of the first dose. During the date of the missed medication, the resident had ongoing agitation and behaviours such as wandering and pacing. The resident had an altercation with another resident that resulted in injury to that resident.

Staff acknowledged the newly increased medication was ordered to keep the resident calm, and that there was a potential for increased pain and more behaviours in the resident due to the missed dose. The DOC confirmed that the medication was not provided to the resident as ordered, and that when the medication error was found, it was reported, and the medication discarded as per the home's policies and procedures.

When the medication ordered to address the resident needs were not provided as prescribed, there was a potential risk for increased behaviours as well as a risk to resident safety.

Sources: Interviews with DOC and other staff; resident clinical record including progress notes, eMAR; medication incident report.

WRITTEN NOTIFICATION: Emergency Plans, CMOH AND MOH

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272

CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

During a confirmed infectious disease outbreak on identified units from identified dates between March and April 2024, the licensee failed to ensure that all applicable directives and recommendations made by the Chief Medical Officer of Health (CMOH), or medical officer of health were followed in the home. Specifically, high touch surfaces throughout all common areas accessed by residents were not cleaned and disinfected at minimum twice daily on specified dates during an outbreak.

Prior to April 19, 2024, the Minister's Directive: COVID-19 response measures for long-term care homes identified that enhanced environmental cleaning and disinfection for frequently touched surfaces are to be performed in accordance with the best practices from Provincial Infectious Diseases Advisory Committee on Infection Prevention and Control's (PIDAC-IPC). The best practices from PIDAC-IPC identified that high-touch surface cleaning and disinfection should be performed at least daily and more frequently if the risk of environmental contamination is higher, using a risk stratification matrix to determine the frequency of cleaning.

As of April 19, 2024, the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, section 3.12 for enhanced environmental cleaning and disinfection, recommended the minimum twice daily cleaning and disinfecting of high touch surfaces for common areas, treatment areas, dining areas and lounge areas.

Rationale and Summary

The frequency of cleaning was identified in the home's policies and outlined that enhanced daily cleaning was required when in outbreak due to it being a very high-risk category. The frequency identified in the policies for outbreaks was for all high touch areas throughout the unit disinfected twice daily.

On an identified date, an identified area of the home was in a declared infectious disease outbreak that lasted until another identified date. During that time, daily high touch cleaning records used by the housekeeping staff on day and afternoon shifts would confirm that the high touch cleaning was completed.
On specific identified dates, day shift high touch cleaning records were not completed for the outbreak unit. The missing cleaning records were also identified during the Infection Prevention and Control (IPAC) Managers audits of records, and education provided at the time to housekeeping staff.

The IPAC Manager and Environmental Services Manager (ESM) acknowledged that the expectation for documentation in the cleaning records was to confirm that the task of twice daily cleaning was completed, and that due to the missing information on the identified dates, it could not be established that high touch surfaces were cleaned more than once daily.

There was a potential of disease transmission during an outbreak when the home failed to implement their policies and procedures in alignment with the PIDAC best practices and CMOH recommendations for twice daily cleaning and disinfecting of high touch surfaces.

Sources: Interviews with housekeeping aide, IPAC Manager, and ESM; high touch cleaning records; high touch cleaning IPAC audits; post outbreak meeting summary; the home's Standard Cleaning in a Healthcare Environment Policy, revised date

August 31, 2023; Critical Incident Report 2618-000008-24; Recommendations for Outbreak Prevention and Control in institutions and Congregate Living Settings, section 3.12 (page 35) dated April 2024; Minister's Directive: COVID-19 response measures for long-term care homes, effective date August 30, 2022 until revoked April 19, 2024; Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition, dated April 2018.