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
Apr 7, 2022	2022_823653_0007	012219-20, 013992-20, 014573-20, 015254-20, 016841-20, 019555-20, 003099-21, 008438-21	Critical Incident System

Licensee/Titulaire de permis

Partners Community Health
2180 Speakman Drive Mississauga ON L5K 1A9

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

Camilla Care Community
2250 Hurontario Street Mississauga ON L5B 1M8

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

ROMELA VILLASPIR (653), DANIELA LUPU (758), SARAH KENNEDY (605)

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): March 3-4, 7-11, 14-17, 2022.

The following intakes were inspected in this Critical Incident System (CIS) Inspection:
Log #012219-20 was related to a medication incident, and neglect;
Log #013992-20 was related to falls prevention and management, and neglect;
Log #014573-20 was related to continence care, and unsafe transfer;
Log #015254-20 was related to maintenance services, and neglect;
Logs #016841-20 and #019555-20 were related to skin and wound;
Log #003099-21 was related to unsafe transfer;
Log #008438-21 was related to falls prevention and management.

Complaint inspection #2022_823653_0008 was completed in conjunction with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the residents, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Agency RPNs, Registered Nurses (RNs), Student Nurse (SN), Physiotherapist (PT), Nurse Practitioner (NP), Housekeeper (HK), Maintenance, Director of Environmental Services (DES), Infection Prevention and Control (IPAC) Lead, Associate Directors of Care (ADOCs), Director of Care (DOC), and the Executive Director (ED).

During the course of the inspection, the inspectors toured the home, observed IPAC practices, meal services, provision of care, reviewed clinical health records, staffing schedules, the home's investigation notes, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **9 WN(s)**
- **8 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. 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 a resident's written plan of care sets out clear directions to staff and others who provided direct care to the resident.

An External Care Provider (ECP) initiated a preventive dressing for a resident. This dressing was not reflected on the resident's written plan of care, and there were no directions in relation to continuing the dressing on their electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) for 11 days.

The Associate Director of Care (ADOC) acknowledged that the dressing was supposed to be continuously applied by the registered staff as recommended by the ECP, and directions in regards to the dressing should have been indicated on the eTAR.

By not including clear directions regarding the preventive dressing, the registered staff may not have applied the dressing consistently.

Sources: Critical Incident System (CIS) report, resident’s eMAR and eTAR, progress notes; Interview with the ADOC. [s. 6. (1) (c)]

2. The licensee has failed to ensure that a resident was reassessed and their plan of care was reviewed and revised when they no longer required continuous oxygen therapy.

A resident's plan of care directed staff to give continuous supplemental oxygen every shift.

On 19 occasions, supplemental oxygen was not needed based on the resident's oxygen levels.

By not revising the resident's plan of care when the resident's needs changed and continuous supplemental oxygen therapy was no longer necessary, it increased the risk that the resident received an intervention they no longer required.

Sources: Resident's progress notes, physician's orders, eMAR; Interview with the ADOC. [s. 6. (10) (b)]

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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written protocol for an elevator failure was complied with.

Long-Term Care Homes Act (LTCHA), 2007, s. 87 (1) (a) requires homes to have emergency plans in place including measures for dealing with emergencies.

Ontario Regulation (O. Reg.) 79/10, s. 230 (4) (1) (viii) requires that the emergency plans provide for dealing with the loss of one or more essential services.

The home's policy titled "Code Grey-Infrastructure Loss/Failure", indicated that when elevators malfunction or fail, a Code Grey should be announced and a debrief should be recorded on the Incident Management System (IMS) 1001 form.

On February 17, 2020, both elevators in the home stopped functioning. There was no record of the incident kept at the home.

The home's Executive Director (ED) said a Code Grey should have been announced and a debrief to include the persons involved and their roles, the actions taken and an action plan to prevent recurrence should have been documented. The home's ED and the Director of Environmental Services (DES) could not locate any records of the incident at the home.

Sources: CIS report, the home's Code Grey Infrastructure Loss/Failure policy, resident's progress notes; Interviews with the home's ED, DES, and other staff. [s. 8. (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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting two residents.

A resident did not receive the level of assistance they required during a transfer.

By not receiving the level of assistance they required during the transfer, there was potential for significant risk of injury to the resident.

Sources: CIS report, resident's clinical health records, the home's investigation notes; Interviews with a PSW and ADOC. [s. 36.]

2. A resident did not receive the level of assistance they required when they were toileted.

As a result of the incident, the resident sustained an injury.

A Registered Nurse (RN) and the ADOC confirmed that the PSW did not use safe transferring techniques when they assisted the resident.

Sources: CIS report, the home's investigation notes, resident's plan of care and chart; Interviews with PSWs, a Registered Practical Nurse (RPN), RNs, and ADOC. [s. 36.]

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 use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, 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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that two residents received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, when the residents exhibited altered skin integrity.

A PSW and RPN noted wound dressings on a resident. Upon assessment, skin tears were noted. At that time, there was no initial skin assessment and no other related documentation for the skin tears.

By a registered staff not completing a skin assessment in relation to the skin tears, other registered staff and PSWs were not made aware of the new skin impairment. The progression of the skin tears may not have been monitored for a time period, and appropriate treatment may not have been consistently provided.

Sources: CIS report, resident’s Point Click Care (PCC) skin assessments, progress notes, eTAR, eMAR; Interviews with a RN, and ADOC. [s. 50. (2) (b) (i)]

2. An ECP informed the former ED about a resident’s altered skin integrity. An internal investigation was initiated, and it was identified that the altered skin integrity was first noted approximately a month earlier. The assigned RPN did not complete an assessment using the electronic head to toe assessment for the intact skin alteration.

By not completing a skin assessment, the progression of the altered skin integrity may not have been consistently monitored, as the staff were not aware when it was first identified.

Sources: CIS report, resident’s PCC skin assessments, progress notes; Interview with the ADOC. [s. 50. (2) (b) (i)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record of a complaint related to the care of a resident, staffing shortage, and operations of the home, including the actions taken to solve the complaint, date of the action taken to solve the complaint, time frames for the action to be taken, and any follow-up action required, was kept in the home.

A family expressed concerns related to the care of a resident and the operations of the home.

The home's internal concern form did not include the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required.

The home’s ED said they could not locate any investigative notes of the complaint.

Sources: Resident's progress notes, the home's complaints log, investigation notes, and the home's policy titled "Complaints Management"; Interview with the ED. [s. 101. (2)]

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 a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written protocols for transcribing a prescriber's orders were implemented for two residents, and the written protocols for stopping a prescriber's orders were implemented for one resident.

In accordance with O. Reg. 79/10, s. 114 (1) and in reference to s. 114 (2), the licensee was required to ensure that written policies and protocols for the medication management system ensure the accurate administration of all drugs used in the home.

The home's policy titled "Physician's/Nurse Practitioner's Orders", directed staff to follow the pharmacy provider policy when transcribing physician's or nurse practitioner's orders and to process the orders as outlined in the policy titled "Physician-Nurse Practitioner Orders Guidelines".

A) The pharmacy provider's policy titled "Transcribing Prescriber's Orders to eMAR", indicated that new medication orders must be transcribed exactly as communicated by the prescriber. If a medication is stopped, the nurse transcribing the stopped order removes the medication from the eMAR and all stopped medications from the cart.

i) A resident had pain related to an injury, and required changes in their pain medication regimen. The Nurse Practitioner (NP) ordered a narcotic analgesic PRN (as needed), with a limit to how many can be given in a day.

The order was transcribed to the eMAR incorrectly, resulting in the resident receiving three extra doses of the PRN narcotic analgesic in a span of two days. The resident required hospitalization as a result of this incident.

ii) The NP ordered to stop a resident's PRN narcotic analgesic. The resident's Individual Monitored Medication Record (IMMR) documented that the medication was given after the order was stopped. The medication was not removed for destruction until two days after it was stopped.

The home's Medication Management Lead/ ADOC #101 and the Director of Care (DOC) said two registered staff should check the prescriber's orders for accuracy by comparing the written order with the eMAR and notify the pharmacy and the prescriber if any discrepancies were noted. They also said that medications should be discarded for destruction once stopped.

By not following the written protocols for transcribing the prescriber's orders and stopping orders, it put the resident at risk associated with improper administration of opioid medications.

Sources: Resident's progress notes, eMAR, physician's orders, IMMRs, the home's Transcribing prescriber's orders to eMAR policy, the home's Physician's/Nurse Practitioner's Orders policy; Interviews with the DOC, ADOC, and other staff.

B) The home's Physician-Nurse Practitioner Orders Guidelines policy said that all prescribing orders for medications and treatments should include medication name, dosage, route, and frequency. The physician should be notified in a timely manner in the event the medication order was incomplete, unclear, inappropriate, or misunderstood.

i) A resident had a medical condition and required PRN supplemental oxygen. A physician prescribed oxygen therapy for the resident, however, the order did not include the flow rate, frequency, and method of administration.

On three occasions in a three-day period, the resident's oxygen saturation was below the prescribed levels, and no action was taken to adjust the oxygen flow rate to maintain the prescribed saturation levels. The resident was sent to hospital as their condition worsened.

The DOC and ADOC said that the oxygen order should include the flow rate, method of administration, and frequency of administration, and the physician should be called to clarify the order.

Not ensuring the oxygen order included the requirements as specified in the home's

policy contributed to the lack of appropriate measures being implemented when the resident’s oxygen level was below the prescribed levels.

Sources: Resident’s progress notes, physician’s orders, eMAR, weights and vitals summary report, the home's Physician’s/Nurse Practitioner’s Orders policy, Physician-Nurse Practitioner Orders Guidelines policy; Interviews with the DOC, ADOC, and other staff.

ii) A resident had a medical condition, and required PRN supplemental oxygen.

A physician prescribed oxygen therapy for the resident, however, the order did not include the flow rate, frequency, and method of administration.

The resident's oxygen saturation levels during a three-day period were reviewed, and fluctuation in their oxygen saturation levels was noted. The resident required oxygen to be started four times. The flow rate and method of administration for the oxygen were not always stated.

The DOC and ADOC said that the oxygen order should include the flow rate, frequency, and method of administration, and the physician should be called to clarify the order.

Not ensuring the oxygen order included the requirements as specified in the home’s policy, and not ensuring the physician was notified to clarify the order, increased the risk that the resident did not receive the appropriate oxygen therapy when their oxygen level was below the prescribed levels.

Sources: Resident’s progress notes, physician’s orders, eMAR, weights and vitals summary report, the home's Physician’s/Nurse Practitioner’s Orders policy, Physician-Nurse Practitioner Orders Guidelines policy; Interviews with the DOC, ADOC, and other staff.

2. The licensee has failed to ensure that the written protocols for documenting controlled medication administration were implemented for two residents.

The pharmacy provider’s policy titled “Individual Monitored Medication Record”, directed staff to document the administration of the monitored medications on the resident's eMAR. The policy also said to sign on the IMMR each time a dose was given and include the date, time, amount given and new quantity remaining.

A) A resident's IMMR for a narcotic analgesic documented that two doses were given at two different times, but there was no documentation of the administration on the resident's eMAR. On the same day, the resident's eMAR and medication audit report showed that another narcotic analgesic was given to the resident at three different times. There was no documentation of these narcotic analgesic doses on the resident's IMMR, and there was no record to indicate from where the doses were provided.

B) A narcotic analgesic was ordered for a resident. On one occasion, the resident's IMMR documented that the narcotic analgesic was given, and there was no documentation on the eMAR regarding the administration.

The home's Medication Management Lead/ ADOC, and the DOC said controlled medications should be documented right after the administration on the resident's eMAR and on the IMMR.

Discrepancies and gaps in the narcotic analgesic administration, and documentation increased the risk of medication errors and negative outcomes associated with incorrect administration.

Sources: Residents' physician's orders, eMARs, medication audit reports, IMMRs, progress notes, the home's Individual Monitored Medication Record policy; Interviews with the DOC, ADOC, and other staff. [s. 114. (3) (a)]

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 written policies and protocols for the medication management system must be developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were given to two residents in accordance with the directions for use specified by the prescriber.

The following is further evidence to support the order issued on September 29, 2020, during inspection 2020_556168_0013 with a compliance due date of October 8, 2020.

A) A resident's pain regimen included an order for a narcotic analgesic given at regular times during the day, and PRN with a specified limit to how many can be given in a day.

Within a span of two days, the resident received three extra doses of their PRN narcotic analgesic. The resident was sent to hospital as a result of this incident.

The two ADOCs said the order for the PRN narcotic analgesic was processed incorrectly and did not include the specified limit to how many can be given in a day.

By not giving the narcotic analgesic at the frequency that it was prescribed, it resulted in harm to the resident.

Sources: CIS report, resident's progress notes, physician's orders, eMAR, IMMR, the home's investigation notes; Interviews with ADOCs, the DOC, and other staff.

B) A resident's pain regimen included an order for a narcotic analgesic three times daily.

On one occasion, the resident's IMMR documented that their narcotic analgesic was given, but there was no documentation of the administration in the resident's eMAR. A review of the home's video-surveillance by ADOC #101 showed that the resident did not receive one dose of their narcotic analgesic.

The ADOC said that the RN did not give the narcotic analgesic as ordered by the prescriber.

By not giving the medication as ordered by the prescriber, there was an increased risk that the resident's pain was not managed adequately.

Sources: Resident's progress notes, eMAR, IMMR, summary of the home's video-surveillance; Interviews with ADOC, and the DOC. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #8: 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 home's Infection Prevention and Control (IPAC) program.

The home's policy titled "Hand Hygiene", directed the PSWs/ Health care Aide and Recreation/ Program Team to wash the residents' hands before and after eating, with Alcohol-Based Hand Rub (ABHR) if hands were not visibly soiled.

During Inspector #653's meal service observation in a resident dining room, 15 out of 16 residents were not assisted with performing hand hygiene after the meal service.

By not assisting residents with performing hand hygiene using the ABHR after a meal service, there was potential for the spread of infectious microorganisms.

Sources: Home's Hand Hygiene policy; Inspector #653's observation; Interviews with the RN, and IPAC Lead. [s. 229. (4)]

2. The home's policy titled "Personal Protective Equipment (PPE)", directed team members to perform hand hygiene after removing their mask or N95 respirator.

During Inspector #653's observation, outside of a resident's room, a RN performed hand hygiene, doffed their N95 respirator, and applied a clean surgical mask with both hands.

The IPAC Lead stated that the expectation was for the RN to doff their N95 respirator, perform hand hygiene, and don a new surgical mask.

Sources: The home's Personal Protective Equipment policy; Inspector #653's observation; Interviews with the RN, and IPAC Lead. [s. 229. (4)]

3. The home's policy titled "Personal Protective Equipment", provided direction on how to ensure the N95 respirator is properly applied and sealed correctly.

During Inspector #653's observation, a team member was inside a resident's room that was on droplet and contact precautions, and they were wearing an N95 mask over their surgical mask, which affected their ability to seal the N95 respirator.

The IPAC Lead stated that the team member should not have been wearing two masks.

Sources: The home's Personal Protective Equipment policy; Inspector #653's observation; Interviews with the team member, and IPAC Lead. [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 home's IPAC program, to be implemented voluntarily.

WN #9: 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 a resident was protected from neglect.

The following is further evidence to support the order issued on September 29, 2020, during inspection 2020_556168_0013 with a compliance due date of October 8, 2020.

For the purpose of the Act and this Regulation, neglect means the failure to provide a resident with the treatment, care services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well-being of one or more residents. O. Reg. 79/10, s.5.

A resident had a medical condition, and required oxygen therapy to maintain their oxygen saturation level.

The resident's oxygen saturation level was documented to be low despite oxygen being given, and it was not checked until 12 hours later, at which point their oxygen saturation level still remained low. There was no action taken to address the resident's low oxygen saturation levels until the NP was notified, and the resident's oxygen saturation level was noted to be lower. The resident was transferred to the hospital when their condition worsened.

The ADOC and RN said that staff did not take appropriate actions when the resident's oxygen saturation level was below their prescribed range, as required.

The lack of monitoring, assessments, and actions to address the resident's low oxygen saturation level resulted in harm to the resident.

Sources: CIS report, resident's progress notes, physician's orders, weights and vitals summary report, the home's investigation notes; Interviews with the RNs, and ADOCs. [s. 19. (1)]

Issued on this 12th day of April, 2022

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

Original report signed by the inspector.