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
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Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901
centralwestdistrict.mltc@ontario.ca

Amended Public Report (A2)

Report Issue Date: February 21, 2023
Inspection Number: 2022-1541-0001
Inspection Type: Critical Incident System
Licensee: Corporation of the County of Dufferin
Long Term Care Home and City: Dufferin Oaks, Shelburne

Inspector who Amended	**Inspector Digital Signature**
April Racpan (218)	April Joy Racpan Digitally signed by April Joy Racpan Date: 2023.02.21 11:29:02 -05'00'

Additional Inspector(s) N/A

AMENDED INSPECTION REPORT SUMMARY

The licensee inspection report has been amended related to the home's request for a compliance due date (CDD) extension to March 24, 2023.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 24-25, 28-30, December 1-2, and 5-8, 2022.

The following intake was inspected:

- Intake: #00013160 related to falls prevention and management.

The following intakes related to falls prevention and management were completed in this inspection:

- Intake: #00001296
- Intake: #00002114
- Intake: #00003731
- Intake: #00003829
- Intake: #00005533

- Intake: #00006830
- Intake: #00010750
- Intake: #00011431
- Intake: #00011916

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

Falls Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

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

Non-compliance with: O. Reg. 246/22, s. 102 (7) 11.

The licensee has failed to ensure that there is in place a hand hygiene (HH) program that is in accordance with the Infection Prevention and Control (IPAC) Standard issued by the Director pursuant to section 102 (2) (b) of the Regulation under the Fixing Long-Term Care Act (FLTCA), 2021.

Rationale and Summary
According to O. Reg 246/22, s. 102 (2) (b), the licensee is required to implement any standard or protocol issued by the Director with respect to IPAC. The IPAC Standard for Long-Term Care Homes (LTCH) dated April 2022, provided additional requirements for IPAC programs in LTCHs.

A) The IPAC Standard section 10.1, states that the HH program should include access to 70-90% alcohol-based hand rub (ABHR) that is easily accessible at both point-of-care and in other resident common areas.

Multiple observations and interviews demonstrated the use of Isagel ABHRs at 60% alcohol level for the following resident care tasks:
-medication administration passes on all resident home areas (RHA)
-dining services on all RHAs

-donning and doffing personal protective equipment (PPE) when entering/exiting an isolation room
-screening process for individuals entering/exiting the building

The Central West (CW) IPAC Hub Representative and Public Health (PH) Inspector stated that Isagel ABHR with an alcohol level of 60% was not considered appropriate for use for HH activities in LTCH settings.

B) The IPAC Standard section 10.4 a) and h) states that the HH program should include HH signages as well as staff support to perform HH for residents prior to receiving meals and snacks.

The IPAC Lead said staff were expected to help residents with performing HH before they ate their meals or had their snacks. It was expected that staff remind and offer HH assistance to independent residents and provide physical assistance to residents with cognitive or physical impairments.

Observations were done at meal and snack time services where several residents were not seen being offered or assisted with hand hygiene before they ate their meals or snacks.

There was no HH signages posted throughout the RHAs, specifically within the dining rooms.

The IPAC Lead said that resident HH was considered an area that required improvement at the home.

C) The IPAC Standard section 10.4 d) states that HH activities shall be linked and included in the home's overall IPAC audit, evaluation, and quality approach for the full IPAC program.

The home's HH program had not been reviewed or revised since January 2020. The program did not include the IPAC standards related to the use and accessibility of 70-90% HH agents, HH signage, resident HH indications, and the audits of resident HH activities.

Not ensuring that the home's HH program was in accordance with the IPAC Standard placed residents and staff at potential risk for contracting and transmitting infectious diseases.

Sources: dining and snack observations, use of Isagel ABHR observations, LTCH's Hand Hygiene Policy #3-060, the IPAC Standard (April 2022), Public Health Ontario (PHO) – Selection and Placement of ABHR During COVID-19 in LTCHs and Retirement Homes (November 6, 2020), interviews with the IPAC Lead, direct care staff, residents, and a visitor. [218]

WRITTEN NOTIFICATION: DIRECTIVES BY MINISTER

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021 s. 184 (3).

The licensee has failed to comply with the Minister's Directive: COVID-19 Response Measures for LTCHs, dated August 30, 2022, when they used expired ABHRs in the home.

In accordance with the Minister's Directive: COVID-19 Response Measures for LTCHs, the licensee is required to follow the Ministry of Health (MOH) COVID-19 Guidance: LTCHs and Retirement Homes for Public Health Units (PHU) Version 8, dated October 6, 2022, for additional IPAC measures.

Rationale and Summary:

The MOH COVID-19 Guidance: LTCHs and Retirement Homes for PHUs document referenced the PHO fact sheet, Selection and Placement of ABHR during COVID-19 in LTCHs and Retirement Homes dated November 6, 2020, which states not to use expired ABHR products and to note the product expiration date when selecting products.

On a specific day in November 2022, there were expired ABHRs identified in resident rooms on the first floor. An impromptu audit was completed by the IPAC Lead for all resident rooms and common areas, including the dining rooms. The audit results showed a total of 34 out of 160 resident rooms with expired ABHR throughout all RHAs. Two out of five dining rooms located on the East Luther/Grand Valley and Dufferin County/Amaranth RHAs also had expired ABHR.

The ABHRs had an expiration date of 07/2022.

Using expired ABHRs throughout the home placed residents at risk of harm from the potential transmission of infection diseases.

Sources: expired ABHR observations, home's ABHR audit records, Minister's Directive: COVID-19 Response Measures for LTCHs (August 30, 2022), MOH COVID-19 Guidance: LTCHs and Retirement Homes for PHUs Version 8 (October 6, 2022), PHO – Selection and Placement of ABHR During COVID-19 in LTCHs and Retirement Homes (November 6, 2020), interviews with the IPAC Lead and other staff.

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i).

The licensee has failed to ensure that when a resident exhibited altered skin integrity on two specific areas, that they received a skin assessment by the registered nursing staff, using a clinically appropriate

assessment instrument that was specifically designed for skin and wound assessments.

Rationale and Summary

As per the FLTCA, 2021 "altered skin integrity" means potential or actual disruption of epidermal or dermal tissue.

A resident sustained red marks to two specific areas following a fall. A skin assessment was not completed for these injuries. The RPN said they were unsure whether a skin assessment was required when redness was identified as a skin injury post-fall.

The RPN recalled an unknown period of time after the fall, when they saw the resident present with a skin concern to one of the same areas previously identified. They did not complete a skin assessment when they observed the development of the skin injury. They were unsure if the skin concern was related to the same fall where the resident sustained red marks to the same area.

The Skin and Wound Lead said the completion of a skin assessment for when the resident sustained redness on two specific areas were clinically indicated due to the nature of the falls incident and potential progression of the injured areas. They added that the identification of any progressed skin concerns also required a skin assessment to be completed by the registered staff.

There was moderate risk to the resident when they sustained redness on two areas post-fall with subsequent skin concerns to the same area and did not receive a skin assessment by the registered staff. This increased the likelihood that appropriate care would not be in place to treat the skin injury if it started to get worse.

Sources: Point Click Care (PCC) Incident Report/Post-falls Assessments, PCC Skin Assessments, interviews with the Skin and Wound Lead and other staff. [218]

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.

The licensee has failed to ensure that there was a written record of the Falls and Skin and Wound evaluation programs that included the date of the evaluation, a summary of the changes made and the date that those changes were implemented.

Rationale and Summary

The written records for the 2022 Falls program and the 2021 Skin and Wound program evaluations were reviewed. The DOC said that the 2022 Skin and Wound program evaluation had been completed but they were not able to produce a written record.

Neither of the program evaluations included a date of when the evaluations were completed, a summary of when changes were made, and the dates that those changes were implemented.

Sources: Home's program evaluation records, Falls and Skin and Wound policies, interviews with the DOC. [218]

COMPLIANCE ORDER CO #001 FALLS PREVENTION AND MANAGEMENT

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

The licensee has failed to comply with O. Reg. 246/22, s. 54 (2).

The licensee shall:

1) Review and update the Falls Prevention and Management program in accordance with evidence-based practices. The review must ensure that the program and related policies include:

a) direction for Personal Support Workers (PSW) and Nursing Assistants/students related to their role and responsibilities when responding to falls incidents

b) direction for registered staff related to their role and responsibilities when completing post-falls assessments

2) Educate all direct care staff (including PSWs, Nursing Assistants/students) and registered staff on the updated Falls Prevention and Management policy.

3) Complete a weekly audit on each resident home area for the following:

a) completion of post-falls assessments for all falls incidents

The audits must be completed for four weeks or until such time as compliance is achieved.

4) Maintain a written record of steps 1-3. This must include the following:

a) date(s) of when the changes to the policy were made,
b) date(s) of when the re-training and education was provided,
c) name(s) of the person(s) responsible for the training and audits
d) the signatures of the participants who attended the training

e) any corrective actions taken related to the audit records

Grounds

Non-compliance with: O. Reg. 246/22, s. 54 (2)

The licensee failed to ensure that when resident #001 fell on two occasions, the resident was assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary

Resident #001 was transferred to the hospital due to a health decline. At the hospital, it was identified that resident #001 had pre-existing injuries.

Resident #001's falls history indicated that they sustained a significant amount of falls within the past three months. Specifically there were two falls incidents, where resident #001 fell and was immediately assisted off the floor, before a post-fall assessment was conducted. In these two incidents, information on the post fall assessment was either incomplete or inaccurate as they did not assess the resident at the time of the fall.

The Nursing Assistant (NA) who worked during one of the incidents acknowledged that they did not notify the RPN after discovering resident #001 on the ground. The NA said they felt PSW notification was sufficient and that notifying the nurse was not a part of their responsibility.

The Falls Lead clarified that registered staff were expected to complete a post-fall assessment of the resident while the resident was still on the floor. Additionally, PSWs and any other staff that witnessed the fall were responsible for immediately notifying the nursing staff and staying with the resident until the nurse arrived to complete the post-fall assessment. These expectations were not specified in the home's Falls Prevention and Management policy.

The Falls Prevention and Management policy did not provide clear direction for staff regarding their responsibilities when responding to falls incidents and completing post-fall assessments. This placed resident #001 at actual risk of harm because the post-falls assessments were not completed at the time of the falls which resulted in inaccurate assessment information. Moving the resident prior to an assessment may have prevented staff from early identification of injuries and/or exacerbation of any injuries sustained during the falls.

Sources: CI report, resident's profile and clinical health records, PCC Progress Notes and Falls Risk Assessment, PCC Incident Report/Post-Fall Assessments, LTCH's Falls Prevention and Management

Policy #NS 9-010 revised September 2019, interviews with the Falls Lead, DOC, the RPN, the NA, and other staff. [218]

This order must be complied with by March 24, 2023

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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.