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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Original Public Report

Report Issue Date: July 12, 2024
Inspection Number: 2024-1541-0003
Inspection Type: Critical Incident
Licensee: Corporation of the County of Dufferin
Long Term Care Home and City: Dufferin Oaks, Shelburne

Lead Inspector	**Inspector Digital Signature**
Brittany Nielsen (705769)	Brittany Nielsen Digitally signed by Brittany Nielsen Date: 2024.07.17 09:18:43 -04'00'

Additional Inspector(s)
Bhavin Mistry (000863)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 26-28, July 3-5, 2024

The following intake(s) were inspected:

- Intake: #00114116 - related to a suspected incident of resident to resident abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive Behaviours

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

Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that strategies were implemented to respond to responsive behaviours demonstrated by a resident.

A) The licensee failed to ensure that a resident was removed from potential triggers of inappropriate behaviours, as indicated in the resident's care plan.

Rationale and Summary

A resident was brought to a program and was situated near co-residents. It was identified by staff that the resident had potential triggers nearby. The resident then demonstrated responsive behaviours.

By failing to implement the strategies that were put in place to respond to the resident's responsive behaviours, other residents were put at risk of harm.

Sources: interviews with staff and record review of a resident's clinical records. [000863]

B) The licensee failed to ensure that a resident's interventions for behavioural

management were implemented, as indicated in their care plan.

Rationale and Summary
A resident was brought to a common area and left alone with no staff supervision for approximately five minutes while being situated near other residents. The resident's care plan stated they were to be monitored at all times, due to their responsive behaviours.

Staff identified that the resident was required to be monitored at all times to reduce or prevent any inappropriate behaviours or expressions.

By failing to ensure the resident's interventions for behavioural support were implemented, there was potential for the resident to cause harm to other residents through inappropriate behaviours or expressions.

Sources: observation of the resident, record review of a resident's clinical records and interviews with staff.
[000863]

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 has failed to ensure that a resident's care plan was revised when the

resident's care needs changed.

Rationale and Summary
As a result of an incident, safety checks were implemented for a resident.

Staff indicated that the resident's care plan was where they would go to find information about a resident's care requirements. However, the resident's care plan did not include the safety checks until almost three months after they were implemented, after it was brought to the home's attention.

By failing to update the resident's care plan, there was risk that staff may not have provided the required care to the resident.

Sources: interviews with staff and record review of a resident's clinical records. [000863]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 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).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard issued by the Director, was implemented.

According to the IPAC Standard for Long-Term Care Homes (LTCHs) dated April

2022, section 7.3 (b) directs the licensee to ensure that audits are performed at least quarterly to ensure that all staff can perform the IPAC skills required for their role.

Rationale and Summary

From March to June, 2024, no audits were completed for one department to ensure they could perform the IPAC skills required for their role.

The home was in an outbreak from May to June, 2024, affecting four home areas.

By failing to follow the IPAC Standard and not completing audits for all staff within the home at least quarterly to ensure they could perform the required IPAC skills for their role, there was risk of transmission of infectious agents.

Sources: interviews with staff and record review of the Hand Hygiene and Personal Protective Equipment (PPE) Use audits completed from March to June, 2024 and the IPAC Standard for LTCHs, dated April 2022.
[705769]