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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: April 13, 2023	
Inspection Number: 2023-1018-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: ATK Care Inc.	
Long Term Care Home and City: The Fordwich Village Nursing Home, Fordwich	
Lead Inspector Helene Desabrais (615)	**Inspector Digital Signature** Helene Desabrais Digitally signed by Helene Desabrais Date: 2023.04.17 09:40:07 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 21, 22, 23, 27, 2023

The following intake(s) were inspected:

- Intake #00016292, complaint related to whistle-blowing protection and retaliation;
- Intake #00019702/Critical Incident report related to prevention of abuse and neglect

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

Whistle-blowing Protection and Retaliation

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: BINDING ON LICENSEES

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1. Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that they carried out every operational or policy directive that applies to Long Term Care Homes (LTCHs).

Rationale and Summary

The Ministry of Long-Term Care (MLTC) COVID-19 guidance document for Long Term Care Homes (LTCHs) in Ontario indicated that homes must conduct regular IPAC self-assessment audits following at a minimum the Public Health Ontario's (PHO) COVID-19 Self-Assessment Audit Tool for LTCHs and Retirements Homes, once a week when in outbreak, and every two weeks when not in outbreak.

The home completed the Infection Prevention and Control (IPAC) Self-Assessment Audits using the required tool on January 1 and 23, 2023, and February 22, 2023, and had scheduled the next assessment audit for the end of March 2023. The Director of Care (DOC) acknowledged that the home was not currently conducting IPAC Self-Assessment Audits using the required tool once every two weeks when not in an outbreak.

Sources: The MLTC COVID-19 guidance document for LTCHs in Ontario (dated October 14, 2022), the home's PHO's COVID-19 Self-Assessment Audit Tool for Long-Term Care Homes and Retirements Homes (dated December 28, 2021), interviews with the DOC.
[615]

WRITTEN NOTIFICATION: INFECTION AND PREVENTON CONTROL PROGRAM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1. Non-compliance with: O. Reg. 246/22, s. 102 (15) 1.

The home has failed to ensure that the designated infection prevention and control lead worked regularly in that position on site at the home at least 17.5 hours per week.

Rational and Summary

The DOC of the home stated they worked 6 hours a week as the designated IPAC Lead. The home has a bed capacity of 26 beds and the DOC acknowledged that they should at least work as an IPAC Lead 17.5 hours per week.

Sources: The home's staff schedule and interview with the Administrator, the DOC and the Administrative Assistant.
[615]

COMPLIANCE ORDER CO #001 DUTY TO PROTECT

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee shall:

a) Complete an audit for a resident of all skin and wound assessments for a period of two weeks to ensure that the registered staff have conducted skin assessments using a clinically appropriate assessment instrument for all areas of altered skin integrity.

b) Complete an audit for a resident, once per week, of their weekly skin and wound assessments for a period of four weeks to ensure that registered staff have provided weekly skin assessments, for altered skin integrity using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment until it is resolved.

c) Complete an audit for a resident of pain assessments for a period of two weeks to ensure that registered staff have provided pain assessments using a clinically appropriate assessment instrument that is specifically designed for pain assessment.

d) Complete medication pain administration audits for a period of two weeks to ensure that registered staff have administered the resident's medication in accordance with directions for use specified by the prescriber when the resident demonstrated pain and was assessed.

e) All audits in a), b), c), and d) of this order should include the date, name of the resident, their skin concerns, whether the assessment was completed, what actions were taken as a result of the audit.

f) Ensure that the resident's plan of care is revised and includes specific interventions that gives clear directions to staff related the assessments and reassessments for pain and skin management.

g) Ensure that the resident is assessed, and it is documented, for transfers and repositioning to ensure that when they are transferred and positioned, staff use devices and safe techniques that maintain or improve, wherever possible, the resident's weight bearing capability, endurance, and range of motion.

Grounds

The licensee has failed to ensure that a resident was not neglected by the licensee or staff.

"neglect" is defined as 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. 256/22. s. 7.

"Altered skin integrity" is defined as a potential or actual disruption of epidermal or dermal tissue. O. Reg. 256/22. s. 55 (3).

A Personal Support Worker (PSW) reported to a nurse that a resident had an altered skin integrity. No skin assessment was completed for the resident at that time or during the week that followed. A week later, the resident 'skin condition was worsening, and they were diagnosed with injuries. No weekly skin assessments were completed for almost two months after.

The resident's plan of care did not include interventions to direct staff to complete skin assessments and reassessments when the resident had an altered skin integrity. The RPN-RAI Coordinator stated that the Skin documentation tool in Point Click Care (PCC) should have been completed for the resident and their plan of care should have given registered staff clear directions to assess and reassess the resident's skin condition.

On five different days, a resident was observed being in pain and their plan of care did not include interventions to direct staff to complete pain assessments and reassessments when they were experienced pain. The resident's physician's orders, during that time, directed the staff to administer pain medication when needed and the plan of care directed staff to transfer the resident with the assistance of staff members.

A Personal Support Worker (PSW) stated that the resident was in a lot of pain when providing care and reported the increased pain levels to the nurse but were unaware if the resident was assessed for pain or given medication to relieve the pain. The RPN-RAI Coordinator stated that the plan of care did not provide direction to staff related to pain medication and even with the increased pain demonstrated by the resident, assessments were not conducted. As a result, the resident did not receive additional medication to manage their pain.

The resident plan of care indicated that the resident needed total care and was to be transferred with the assistance of staff members. When the resident was diagnosed with injuries, the DOC said the resident was not reassessed, the plan of care was not revised for skin, pain management, and transfers, stating nothing had changed and they planned to provide the same level of care as prior the discovery of the injuries.

The home's pattern of inaction in relation to not identifying and completing skin and pain assessments delayed the resident's diagnosis and therefore treatment of their injuries which had a significant impact on the resident.

Sources: Resident's clinical record, home's Critical Incident report, interviews with a PSW, an RN, a RPNRAI Coordinator, and the Director of Care.

[615]

This order must be complied with by June 2, 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.