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: March 14, 2024	
Inspection Number: 2024-1203-0001	
Inspection Type: Critical Incident	
Licensee: Golden Dawn Senior Citizen Home	
Long Term Care Home and City: Golden Dawn Nursing Home, Lions Head	
Lead Inspector Kaitlyn Puklicz (000685)	**Inspector Digital Signature** Kaitlyn Joan Puklicz Digitally signed by Kaitlyn Joan Puklicz Date: 2024.03.20 11:43:42 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 20 - 23, 2024

The following intake(s) were inspected:

- Intake: #00103935 - Resident fall resulting in injury and significant change in status
- Intake: #00107342 - ARI outbreak 22JAN24 - 06FEB24

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Directives by Minister

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The Licensee has failed to ensure that where the Act required the Licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30 2022, the Licensee was required to ensure that the Long-Term Care Home (LTCH) completed Infection Prevention and Control (IPAC) audits at least quarterly when not in outbreak and weekly when in an outbreak.

The licensee has failed to ensure that IPAC self-audits were completed every week when the home was in an outbreak.

Rationale and Summary

The home experienced an Acute Respiratory Illness (ARI) outbreak from January 22 to February 6, 2024.

A review of the home's IPAC self-audits provided by IPAC Lead #102 was conducted and audits were completed January 18 and Feb 14, 2024. The home did not complete the IPAC self-audits every week while in outbreak as required by the Minister's Directive.

IPAC Lead #102 confirmed that the home did not complete the IPAC self-audits as required during the outbreak.

Failing to complete IPAC self-audits as required put the home at risk of failing to ensure measures were taken to prepare for and respond to an outbreak.

Sources: Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, COVID-19 guidance document for long-term care homes in Ontario, updated November 7, 2023, IPAC self-audits provided by the home, and interviews with IPAC Lead #102.

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WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 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.

A) The licensee has failed to ensure that a PSW used safe transferring techniques

when assisting a resident.

Rationale and Summary

A Critical Incident (CI) was submitted to the Director stating that a resident had experienced a fall resulting in injury and transfer to hospital.

The resident's care plan provided specific direction in relation to transfers, ambulation and falls.

The home's policy, Safe Resident Handling, effective December 2023, stated that the PSW's responsibility before moving a resident includes assessing their energy levels and physical ability, as well as to consider if additional team member support is required.

On the day of their fall, the level of assistance provided to the resident did not align with their plan of care or their policy on safe resident handling.

The DOC stated that the PSW should have taken a different approach when the resident stated they were feeling weak on the day of their fall.

Sources: CI #2705-000012-23, clinical record for the resident, Safe Resident Handling policy VII-G-20.30, effective December 2023, interview with a PSW and the DOC.

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B) The licensee has failed to ensure that a PSW and an RN used safe transferring techniques when assisting a resident after their fall.

Rationale and Summary

The home's Fall Prevention and Management policy, effective April 2023, stated to ensure a resident is not moved if there is suspicion or evidence of injury and that when moving a resident, to ensure the appropriate lifting procedure is performed.

When the resident fell, they were assisted back up by two staff, in a manner that did not align with the home's policy for falls prevention and management.

The DOC stated the home has a no-lift policy, meaning if resident cannot get up off the floor themselves, then staff must use a mechanical lift. They confirmed that a resident should not be moved or transferred without a mechanical lift if there is evidence of injury. They stated there was risk of further injury to the resident and staff by not using a lift.

Sources: CI #2705-000012-23, the home's Fall Prevention & Management policy VII-G-30.10, effective April 2023, clinical record for the resident, interview with a PSW and the DOC.

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C) The licensee has failed to ensure that a PSW used safe transferring techniques when assisting a resident.

Rationale and Summary

A resident had experienced a fall resulting in injury and transfer to hospital. The resident returned back to the home and was reassessed for transfers and mobility.

A PSW was observed transferring the resident in a manner that did not align with their plan of care. The resident experienced pain as a result of this transfer.

The DOC stated that the PSW should not have transferred the resident in that specific manner because the resident could have been further injured.

Sources: CI #2705-000012-23, clinical record for a resident, interview with an RN, PSW and the DOC.

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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 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

A) The licensee has failed to ensure that all staff participated in the home's Infection Prevention and Control (IPAC) Program, specifically wearing their masks correctly.

Rationale and Summary

The home experienced an ARI outbreak from January 22 to February 6, 2024. During this outbreak, 20 out of 37 residents were affected.

Throughout the inspection, the Inspector observed general IPAC practices and staff compliance within the home.

During observations on two consecutive dates, the Inspector observed at least six staff members wearing their masks improperly, exposing their noses.

The home's policy, Masks, Eye Protection & Face Shields, effective November 2023, stated that "masks must fit securely over the nose and mouth".

IPAC Lead #102 stated all staff, students and volunteers were expected to wear a surgical mask while in the home.

The DOC stated there is risk of transferring infectious diseases when staff wear their masks improperly.

Sources: Masks, Eye Protection & Face Shields Policy, IX-G-10.40, effective November 2023, observations, interviews with the IPAC lead #102 and the DOC.

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B) The licensee has failed to ensure that all staff participated in the home's Infection Prevention and Control (IPAC) Program, specifically assisting residents with hand hygiene prior to meals.

Rationale and Summary

The home's policy, Hand Hygiene, effective November 2023, stated to have residents use Alcohol Based Hand Rub (ABHR) prior to eating.

During a lunch service, the Inspector only observed one resident being provided with hand sanitizer before being served.

IPAC Lead #102 stated that staff were to assist residents with hand hygiene prior to meals.

The DOC stated that residents were at risk of becoming sick from eating with unclean hands when staff did not offer ABHR prior to meals.

Sources: Hand Hygiene Policy, IX-G-10.10, effective November 2023, observations, interview with IPAC lead #102 and the DOC.

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WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under

subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that an outbreak of a disease of public health significance in the home was reported to the Director immediately.

Rationale and Summary

The home experienced an ARI outbreak from January 22 to February 6, 2024.

A Grey Bruce Public Health (GBPH) outbreak report summary declared the outbreak on January 22, 2024.

The home submitted a Critical Incident (CI) to the Director on January 23, 2024.

The DOC acknowledged that the CI was submitted late. They also stated that multiple residents became symptomatic over January 20-21, 2024; and this was not reported to management or public health until January 22, 2024.

The DOC stated there was risk of not receiving proper guidance of how to proceed, as well as a delay in determining the pathogen responsible due to the home's delayed communication with GBPH and the Director when a suspected outbreak occurred.

Sources: GBPH Outbreak Report Summary for outbreak #2233-2024-00011, CI

#2705-000001-24, interview with the DOC.

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