Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton Service Area Office
119 King Street West, 11th Floor
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Original Public Report

Report Issue Date October 3, 2022
Inspection Number 2022-1393-0002
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Henley House Limited

Long-Term Care Home and City
The Henley House, St. Catharines

Lead Inspector
Barbara Grohmann (720920)

Inspector Digital Signature
Lisa Vink Digitally signed by Lisa Vink Date: 2022.10.11 08:25:31 -04'00'

Additional Inspector(s)
Adiilah Heenaye Sumser (740741), Cynthia DiTomasso (528), Lisa Vink (168) and Stephanie Smith (740738)

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 5, 8-12, 15-19, 22, September 7-9, 2022.

The following intake(s) were inspected:
- Log # 012388-22 for a Critical Incident System (CIS) report related to plan of care.
- Log # 014323-22 for a CIS related to plan of care.
- Log # 014789-22 (Complaint) related to air temperatures.
- Log # 014618-22 (Complaint) related to plan of care and medication.
- Log # 014312-22 (Complaint) related to plan of care and staffing.
- Log # 014126-22 (Complaint) related to air temperatures.
- Log # 012850-22 (Complaint) related to plan of care, staffing, infection prevention and control and transferring and positioning.
- Log # 011427-22 (Complaint) related to air temperatures, plan of care, staffing and medications.
- Log # 006231-22 (Follow-up) related to bathing.
- Log # 006222-22 (Follow-up) related to transferring and positioning.
- Log # 011505-22 (Follow-up) related to policies etc., to be followed.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 8 (1) (b)	2022-1393-0001	001	Lisa Vink (168)
O. Reg. 79/10	s. 36	2022-820130-0001	001	Cynthia DiTomasso (528)

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found not to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
O. Reg. 79/10	s. 33 (1)	2022-820130-0002	001	Stephanie Smith (740738)

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

- Admission, Absences & Discharge
- Continence Care
- Falls Prevention and Management
- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Medication Management
- Pain Management
- Palliative Care
- Prevention of Abuse and Neglect
- Quality Improvement
- Recreational and Social Activities
- Reporting and Complaints
- Resident Care and Support Services
- Resident Charges and Trust Accounts
- Residents' and Family Councils
- Residents' Rights and Choices
- Responsive Behaviours
- Restraints/Personal Assistance Services Devices (PASD) Management
- Safe and Secure Home
- Skin and Wound Prevention and Management
- Staffing, Training and Care Standards
- Whistle-blowing Protection and Retaliation

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INSPECTION RESULTS

WRITTEN NOTIFICATION – CONDITIONS OF LICENCE

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

Non-compliance with: LTCHA, 2007, s. 101 (4)

The licensee has failed to comply Compliance Order (CO) #001 from Inspection Report #2022_820130_0002 served on March 29, 2022, for Ontario Regulation 79/10, section (s) 33 (1) with a compliance due date of June 29, 2022.

Rationale and Summary

Routine audits were not completed, nor a record kept until staff were compliant with the contingency plan for bathing when scheduled baths or showers were missed or needed to be rescheduled due to staffing shortages, as required in the CO.

Sources: CO #001 from #2022_820130_0002, interviews with staff, the home's 24-hour report, Point of Care (POC) documentation and plan of care for a resident. [740738]

WRITTEN NOTIFICATION – PLAN OF CARE

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

Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure there was a written plan of care for a resident that set out the planned care related to a prescribed therapy.

Rationale and Summary

On two occasions a resident was observed to use their therapy without an adaptor applied, on a third observation, the adaptor was present but not fully functional.
The clinical health record identified that the resident required the therapy.
A staff identified that the resident used the therapy with the adaptor, which staff were required to maintain to ensure it was functional.
Staff confirmed that the resident requested to use the adaptor with the therapy; and a back up supply of therapy equipment was required when going out of the home, which had been provided by the supplier.
The written plan of care did not set out the planned care for the resident related to when the adaptor was to be used or that the back up supply was required when away from the home.

Sources: Interviews with staff, a resident's clinical health records, electronic Medication Administration Record (eMARS), observations, and a manual. [528]

Non-compliance with: FLTCA, 2021, s. 6 (1) (a)

The licensee has failed to ensure there was a written plan of care for a resident that set out the planned care for the resident related to a referral/assessment.

Rationale and Summary

A resident utilized a device for all transfers.

A concern was voiced related to the use of the device.

A Complaint Investigation Form identified a referral would be submitted to assess the resident related to the concern.

Management reported that they verbally requested a staff member submit the referral.

A review of the clinical record did not include any documentation regarding the concern nor the planned care of a referral.

A referral was not initiated, nor an assessment completed.

Failure to include the planned care of the resident in the written plan of care resulted in the assessment not being completed.

Sources: Review of Complaint Investigation Form, review of the clinical health record of a resident including assessments and progress notes and interviews with staff. [168]

WRITTEN NOTIFICATION – PLAN OF CARE

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

Non-compliance with: FLTCA, 2021, s. 6 (1) c

The licensee has failed to ensure the written plan of care for a resident set out clear directions to staff and others who provided care to the resident related to activities of daily living.

Rationale and Summary

A)A resident identified the level of care they required for toileting.

The plan of care for toilet use noted they were unable to be transferred to the toilet and also directed staff to encourage the resident to ask for assistance to use the commode.

The direction was not clear related to the toileting needs of the resident.

Staff confirmed the required the level of assistance as identified by the resident.

B)A resident was transferred with a device.

There were concerns expressed related to the use of the device.

The plan of care for transfers included that the resident was to use the device to ensure safety; however, did not provide direction for safety considerations related to the device or post transfer care.

Observations of the resident's room included two different devices available for use.

The direction was not clear related to the transferring needs of the resident.

Staff confirmed the plan of care did not provide clear direction and revised the plan related to toilet use and transfers.

Failure to ensure that the plan of care included clear directions had the potential for the resident to be provided care inconsistent with their needs.

Sources: Review of progress notes and plan of care for a resident, interviews with the resident and staff. [168]

WRITTEN NOTIFICATION – PLAN OF CARE

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

Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

The licensee has failed to ensure that staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment of the resident so that their assessments were integrated and consistent with and complemented each other.

Rationale and Summary

A resident's progress notes indicated they were referred to an external service provider in 2021.

The service provider completed an initial assessment and documented the results.

There was no follow-up notes or assessments after the initial assessment, until another referral was submitted in 2022, for the same issue.

A therapist verified the lack of follow-up regarding the initial assessment as they were unaware of the referral and did not collaborate with the provider.

Management staff verified there was a lack of follow-up on the referral, and the staff who initiated the referral was expected to ensure completion.

There was a lack of collaboration between the home, the external service provider, and the therapist.

Failure to collaborate between staff and others may have led to a risk of harm to the resident.

Sources: Interviews with staff, progress notes for a resident, and the home's investigative notes. [740738]

WRITTEN NOTIFICATION – PLAN OF CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that a resident and any other persons designated by the resident were given an opportunity to participate fully in the implementation of the resident's plan of care related to an appointment.

Rationale and Summary

The home area calendar identified a resident had an off-site appointment on a specific day.

A person designated by the resident was in the home, at the time of the scheduled appointment.

The appointment was first communicated to the designated person when the practitioner called the home to cancel the appointment on the same day, due to the late hour.

Staff verified the appointment was not previously known to the resident or the person until the phone call.

Management staff identified it was the expectation the clinical record included the resident/representative was notified of an appointment and that transportation was arranged.

The designated person confirmed they were not aware of the scheduled appointment until after it was missed, the resident had waited a long time for the appointment, and it was their responsibility to arrange transportation.

The resident and their designated person were not given the opportunity to participate fully in the implementation of the plan of care when they were not notified of the appointment.

The resident missed their original scheduled appointment.

Sources: Review of the clinical health record of a resident, review of the home area calendar and interviews with the resident and staff. [168]

WRITTEN NOTIFICATION – PLAN OF CARE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the plan of care was provided to a resident as specified in the plan.

Rationale and Summary

A resident had orders for a therapy continuously at a specific dose and if required, staff could increase the dose to higher level under specific conditions.

The resident was observed with the therapy in place at the higher dose when the specific conditions were not met.

Staff confirmed the therapy was not to be at the higher dose when observed.
The resident was not provided the therapy as specified in their plan of care.
Sources: A resident's clinical health records, interviews with staff. [528]

Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure the care set out in the plan of care was provided to a resident as specified in the plan related to an assessment.

Rationale and Summary

A resident utilized a device for transfers.

A referral was initiated for an assessment of the resident related to the device.

Approximately three weeks later the resident had not been assessed related to the device.

A therapist identified their plan to assess the resident that day; however, noted it was the responsibility of nursing staff to complete assessments related to device.

Failure to assess the resident as set out in the plan had the potential for changes in care needs to not be identified.

Sources: Progress notes and assessments of a resident and interviews with staff. [168]

WRITTEN NOTIFICATION – PLAN OF CARE

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (10) b

The licensee failed to ensure that a resident's plan of care was revised when care in the plan was no longer necessary.

Rationale and Summary

The area immediately outside of a resident's doorway had a sign which identified additional precautions and a personal protective equipment (PPE) cart.

Staff identified the resident was no longer on precautions, the signage to direct staff in the provision of care was not current, and later that shift the sign was removed.

Failure to ensure the plan of care was revised when additional precautions were no longer necessary placed the resident at low risk as the precautions were greater than the resident's assessed needs.

Sources: Observations of a resident's room, review of the clinical record of the resident including the plan of care and progress notes and interview with staff. [168]

Non-compliance with: FLTCA, 2021, s. 6 (10) b

The licensee failed to ensure that a resident was reassessed, and the plan of care revised at any time when their care needs changed.

Rationale and Summary

A resident had a history of a diagnosis, which was noted in their plan of care.

The physician was notified that the resident presented with symptoms and an order was received to conduct a test.

A sample was obtained for testing four days after the order was received and was sent to the laboratory.

Approximately one week after the sample was received the resident's representative voiced concerns that the test results had not been received. Staff proceeded to obtain a copy of the results, confirmed a change in condition, notified the physician, an order was received, and treatment initiated.

At the time of the inspection the clinical record included a laboratory report which was fax stamped three days after the specimen was sent to the laboratory. The report was manually date stamped for the following day, which was four days prior to the representative's concerns. It was unknown who received the report or if any actions were initially taken.

The resident was not reassessed, nor changes made to their plan of care when the report was initially received, despite the confirmed change in the resident's condition.

Action was not taken to reassess the resident and notify the physician until the concern was voiced by the resident's representative.

The resident had a known change in condition for approximately five days without treatment.

Sources: Review of Complaint Investigation Form, the clinical health record of a resident including progress notes, physician's orders, laboratory reports, eMAR and interviews with staff. [168]

WRITTEN NOTIFICATION – DIRECTIVES BY MINISTER

NC #008 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 applied to the home, which included Minister's Directives.

A) In accordance with the Minister's Directive, COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities, the licensee was required to ensure that all health care workers who provided direct care to or interacted with a suspect or confirmed cased of COVID-19 wore eye protection, gown, gloves and N95 respirator (or approved equivalent).

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Rationale and Summary

An outbreak was declared.

A resident, on additional precautions, was in their room when two different staff members were observed to enter their room without the required PPE.

A staff member stated they were told only two residents were diagnosed with a condition and all other residents were on isolation. They believed they did not have to wear full PPE if the resident was on isolation and said that they were not given additional direction or training.

On two different dates staff were observed to perform nasal and throat swabs. The staff did not wear eye protection and stated there were no clean goggles available. Goggles were observed nearby, along with a container of disinfectant wipes.

On another occasion a staff member was observed to perform nasal and throat swabs. Their PPE included only a surgical mask during the procedure. The staff acknowledged they should have worn a gown but believed that eye protection was only needed if the home was in outbreak.

The home's policy, Droplet Precautions and Airborne Precautions, identified that to enter rooms under additional precautions required a gown, gloves, surgical grade mask with visor and fit-tested N95 respirator.

The Nasopharyngeal, Nasal and Throat Swab Collection policy indicated that gloves, mask and eye protection were needed when to complete the procedure.

Niagara Public Health staff confirmed that those who performed routine asymptomatic rapid antigen tests on staff or visitors should have worn a medical mask, gloves, gown and face shield during the process of swab collection.

Management staff stated that those who provided care to residents on specific precautions were to wear a gown, gloves, N95 mask and face shield and confirmed that staff who performed rapid antigen tests were to wear a gown and goggles during the procedure.

Failure to wear appropriate PPE according to additional precautions and public health recommendations had the potential to spread the virus to visitors, staff and/or residents.

Sources: Observations; Droplet Precautions, Airborne Precautions, Nasopharyngeal, Nasal and Throat Swab Collection, Minister's Directive: COVID-19 response measures for long-term care homes, COVID-19 guidance document for long-term care homes in Ontario, Ministry of Health COVID-19 Guidance: Personal Protective Equipment (PPE) for Health Care Workers and Health Care Entities; interviews with staff. [720920]

B) In accordance with the Minister's Directive, COVID-19 Guidance Document for Long-Term Care Homes in Ontario, the licensee was required to ensure that all visitors (general or essential) wore a medical mask for the entire duration of their indoor visit.

Rationale and Summary

A visitor was observed in a resident's room without a medical mask.

A second visitor was observed in the first-floor hallway, approximately 25 metres from the entrance, without a medical mask. The visitor stated they had forgotten to put on a mask and walked back to the waiting area for their rapid antigen test results. No staff stopped or reminded the visitor to don a mask.

Another visitor was observed in the café area of the first floor of the home without a mask. Staff who performed rapid antigen tests reminded the visitor to put on a mask.

Management staff confirmed that everyone was expected to wear a mask in the home and acknowledged they had to provide warnings to visitors for failure to wear masks for the duration of their visit in the home.

Failure to ensure that visitors wore medical masks for the duration of their visit had the potential to spread the virus to visitors, staff and/or residents.

Sources: Minister's Directive: COVID-19 response measures for long-term care homes, COVID-19 guidance document for long-term care homes in Ontario. [720920]

C) In accordance with the Minister's Directive, COVID-19 Guidance Document for Long-Term Care Homes in Ontario, the licensee was required to complete Infection Prevention and Control (IPAC) audits weekly when the home was in outbreak.

Rationale and Summary

An outbreak was declared in the home.

A review of completed COVID-19 Self-Assessment Audit Tools identified that no audits were completed/performed after the outbreak was declared.

Staff confirmed they were aware the audit tool was to be completed weekly when the home was in an outbreak; however, acknowledged that they were behind on the audits.

Sources: COVID-19 Self Assessment Audit Tools, Minister's Directive: COVID-19 response measures for long-term care homes, COVID-19 guidance document for long-term care homes in Ontario; interviews with staff. [720920]

D) In accordance with the Minister's Directive, COVID-19 Guidance Document for Long-Term Care Homes in Ontario, the licensee was required to ensure that all individuals were actively screened for symptoms and exposure history for COVID-19 before they were allowed entry to the home.

Rationale and Summary

Two visitors were observed to enter the home and they proceeded directly to the rapid antigen testing area. Staff attempted to redirect the visitors to complete the required screening.

The visitors stated that they did not need to complete screening as they were just there to meet with a manager. The visitors left the home after they met with the staff member.

Staff stated that visitors did not interact with residents and therefore did not need to complete screening.

Management staff confirmed that all visitors were expected to complete and pass screening when they entered the home.

Failure to ensure that all visitors were actively screened before they entered the home had the potential to introduce or spread the virus to other visitors, staff and/or residents.

Sources: Observations; Minister's Directive: COVID-19 response measures for long-term care homes, COVID-19 guidance document for long-term care homes in Ontario; interviews with IPAC lead and other staff. [720920]

E) In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, the licensee was required to ensure that enhanced environmental cleaning and disinfection for frequently touched surfaces was performed.

Rationale and Summary

Key Elements of Environmental Cleaning in Healthcare Setting and Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings identified that frequently touched surfaces should be cleaned and disinfected more frequently in outbreak areas.

The home's policy, Enhanced Room Cleaning for Pandemic/Outbreak, included that during an outbreak, all horizontal surfaces within reach of residents with suspected or confirmed cases must be cleaned twice daily using a health care grade disinfectant and to ensure surfaces remained wet as per the manufacturer's contact time.

A resident, who resided in a resident home area in an outbreak confirmed that their room was cleaned daily.

Staff stated they only had time to clean resident rooms once per day. They acknowledged they should clean with Oxivir TB disinfectant due to the outbreak but had only Virex available. Virex II 256 was a one step disinfectant cleaner, with a 10-minute contact time and was observed in the home's cleaner dispensing system.

A public health Inspection Report recommended staff cleared with Oxivir TB wipes due to a one-minute contact time that would be more effective.

Failure to ensure enhanced cleaning in outbreak areas had the potential to increase the risk of the virus spread.

Sources: Observations; Public Health Inspection Report, Enhanced Room Cleaning for Pandemic/Outbreak, Minister's Directive: COVID-19 response measures for long-term care homes, Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, Key Elements of Environmental Cleaning in Healthcare Setting; interviews with a resident and staff. [720920]

WRITTEN NOTIFICATION – SAFE AND SECURE HOME

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 23 (4)

The licensee has failed to implement their heat related illness policy and their heat related illness prevention and management plan for temperature monitoring.

In accordance with O. Reg 246/22 s. 11 (1) b, the licensee was required to ensure that there was a plan to monitor hourly temperatures across all three shifts when air temperatures approach 26 degrees Celsius or humidex greater than 30 degrees and the plan must be complied with.
Specifically, staff did not comply with the licensee's Heat Related Illness Policy and their Heat Related Illness Prevention and Management Plan and Humidex Response.

Rationale and Summary

The home's heat related illness prevention and management plan identified:

- To monitor indoor air temperatures of at least two resident bedrooms in different parts of the home, one resident common area on every floor of the home and every designated cooling area, if there were any in the home. The temperatures were required to be measured and documented once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.
- Hourly temperatures were to me monitored when humidex was more than 30 degrees.

The home's procedures in the Heat Related Illness Policy stated that as the air temperatures approached 26 degrees Celsius or humidex was greater than 30 degrees, to increase the frequency of monitoring to hourly across all three shifts.

Management staff confirmed that when air temperatures were 26 degrees Celsius or humidex greater than 30 degrees, hourly monitoring of temperature across all three shifts was not done and that no evening temperatures were taken for any home areas.
Residents were at risk for heat related illnesses when the home's heat plan and policy were not followed.

Sources: Interviews with staff, Policies - Heat Related Illness, Heat Related Illness Prevention and Management Plan and Humidex Response. [740741]

WRITTEN NOTIFICATION – SAFE AND SECURE HOME

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, *s.* 24 (3)

The licensee has failed to ensure that temperatures outlined in section (2) were measured and documented once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary

O. Reg. 246/22, s. 24 (2), identified that air temperatures were to be measured and documented in writing in the following areas of the home:

- At least two resident bedrooms in different parts of the home.
- One resident common area on every floor of the home.
- Every designated cooling area, if there are any in the home.

The home identified specified rooms as the designated cooling areas in each resident home area.
A review of the Huddle Binder Records identified that temperatures were not measured and recorded for all cooling areas on the following occasions:
-June 2022, during the morning on 18 occasions, in the afternoon on eight occasions and not at all during the evening/night.
-July 2022, during the morning on 11 occasions, in the afternoon on 10 occasions and not at all during the evening/night.
-August 2022, during the morning on 10 occasions, in the afternoon on nine occasions and not at all during the evening/night.
Staff reported that the home initiated daily temperature monitoring in July 2022.

Daily Temperature Logs were reviewed and indicated that air temperatures were not measured and documented consistently in at least two resident bedrooms in different parts of the home once a day in the afternoon between 12 p.m. and 5 p.m.

The tool that the home utilized to record temperature monitoring in resident rooms in all home areas was reviewed. The tool had missing rooms or duplicate rooms for just under one month and as a result some residents' room did not have their temperatures documented.

Failure to record air temperatures in accordance with the requirements had the potential for the home to fail to initiate their heat related illness plan for residents when required.

Sources: Daily Temperature Log binder, interviews with staff. [740741]

WRITTEN NOTIFICATION – SAFE AND SECURE HOME

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 24 (4)

The licensee has failed to ensure that for every resident bedroom that was not served by air conditioning, the temperature was measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m.

Rationale and Summary

A Daily Temperature Log for every resident bedroom that was not served by air conditioning was initiated.

A review of Daily Temperature Logs included incomplete entries for all resident rooms for five dates in July 2022 and five dates in August 2022.

Temperature logs reviewed for July and August 2022, were missing room numbers and some temperature readings in each resident home area on different occasions.

Failure to record air temperatures as per requirements might have prevented the home to initiate their heat related illness plan for residents when required.

Sources: Daily temperature log binder and interview with staff. [740741]

WRITTEN NOTIFICATION – CARE PLANS AND PLAN OF CARE

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 29 (3)

The licensee has failed to ensure that a plan of care was based on, at a minimum, an interdisciplinary assessment of a resident's safety risks.

Rationale and Summary

A resident's progress notes identified they sustained an injury when they used a mobility device.

A referral was submitted to an external specialist to request a safety device be added to the device.

In 2021 and 2022, documentation indicated that the resident sustained injuries when they utilized their mobility device.

The home's investigation notes verified that the resident was unsafe when they utilized their device.

A staff confirmed that they did not complete a safety assessment for the resident related to the use of their device.

Staff were aware that the resident was unsafe when they used the device and did not take appropriate action to minimize this risk.

Failure to assess safety risks for the resident led to injuries and risk for further injury.

Sources: Interviews with staff, progress notes for a resident and the home's investigative notes. [740738]

WRITTEN NOTIFICATION – GENERAL REQUIREMENTS FOR PROGRAMS

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 34 (2)

The licensee has failed to ensure that any actions taken with respect to a resident under the nursing and personal support services program, as required in FLTCA, s. 11 (1) or continence care and bowel management program, as required in FLTCA, s.53 (1) including interventions, were documented.

A) The licensee failed to ensure that bathing was consistently documented for three residents.

Rationale and Summary

POC bathing records were reviewed and identified that three residents did not have their bathing consistently documented as required.

Each of the three residents had occasions where bathing was documented as not applicable and/or there was no documentation completed when the care was scheduled.

The home's policy on POC documentation detailed that Personal Support Worker (PSWs) were to indicate on the task if the resident refused or was unavailable, along with documentation when the task was completed.

Staff stated that if bathing was not documented it was likely because there was not enough time to document.

Management identified they expected PSWs to document when a task was completed or notify the Registered Practical Nurse (RPN) of a refusal and that "not applicable" was not acceptable.

Failure to document tasks as required may have resulted in inconsistent care.

Sources: Resident's clinical records, Point of Care Documentation; Point of Care Documentation Policy, and interviews with staff. [702920, 740438 and 168]

B) The licensee has failed to ensure that the home's check and change program, related to continence care and bowel management, was documented for two residents.

Rationale and Summary

The residents' plans of care indicated they were on the home's check and change program that required PSWs to check the residents' continence care products.

Individual POC records for a period of three months for the check and change program were reviewed and identified that the care was not consistently documented as completed or documented as not applicable.

The home's policy on POC documentation detailed that PSWs were to indicate on the task if the resident refused or was unavailable, along with when the task was completed.

Staff stated that if care was not documented it was likely because there was not enough time to document.

Management identified they expected PSWs to document when a task was completed or notify the RPN of a refusal and that "not applicable" was not acceptable.

Failure to document tasks as required may have resulted in inconsistent care.

Sources: Residents' clinical records, Point of Care Documentation; interviews with staff. [702920]

WRITTEN NOTIFICATION – NUTRITION CARE AND HYDRATION PROGRAMS

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 74 (2)(d)

The licensee has failed to comply with the system to monitor and evaluate the fluid intake of a resident with identified risks related to hydration.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that there was a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

Specifically, staff did not comply with the policy Hydration Monitoring in the licensee's Nutrition and Hydration Program.

Rationale and Summary

The home's Hydration Monitoring Policy indicated that the registered staff would monitor fluid intake at night and indicate on the 24-hour shift report if a resident consumed under 1000 milliliters (mls) for that day. Progress notes were to be documented that staff encouraged fluid intake and whether their attempts were successful or not.

A resident's fluid intake was below 1000 mls on six occasions over a period of approximately two months.

There was no documentation regarding fluids for those days in progress notes and/or the 24-hour shift report.

Their care plan indicated a desired fluid range along with the risk of dehydration due to use of a medication.

Staff stated that the evening nurse would indicate which residents required encouragement on the shift report and they would do so the following day and offer the residents' favourite fluids. They also confirmed that if a resident received fluids independently, from their own supply or family, that would be documented in POC.

Failure to follow the home's Hydration Monitoring policy may have put the resident at risk of dehydration.

Sources: A *r*esident's clinical records; Policy: Hydration Monitoring; and interviews with staff. [720920]

WRITTEN NOTIFICATION – NUTRITION CARE AND HYDRATION PROGRAMS

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 77 (4)

The licensee has failed to ensure that the planned menu items were offered and available at each meal.

Rationale and Summary

A resident reported a concern about the portion sizes provided at lunch and specifically when French fries were on the menu, they usually received only five or six.

Meal service was observed.

The home's therapeutic diet menu indicated portions for tortellini alfredo as 250 mls (two #8 scoops), salad of 80 mls (one #12 scoop), rice as 125 mls (one #10 scoop for minced), one slice whole wheat bread, vegetables as 125 mls (one #10 scoop for minced/pureed) and meatballs (puree one #8 scoop).

Staff used a #10 scoop (90 ml) to plate the tortellini and provided most residents with one and a half scoops.

A #12 scoop (80 ml) was used for minced vegetables and a #16 scoop (60 ml) was used for both the pureed meatballs and vegetables.

Tongs were used to plate the salad and bread was not provided as per the menu.

Staff ran out of the tortellini before all residents received their meal and had to go to another home area for additional portions.

Staff confirmed they used a #10 scoop for the pasta and rice. They did not refer to the therapeutic menu when they selected the scoops for the different foods and textures.

A second meal service was observed.
The home's therapeutic menu indicated portions for battered fish as one piece, four ounces (oz) of French fries (using a 4 oz spoodle), and 125 ml coleslaw (one #10 scoop for minced).
Staff used tongs to portion both the fish and French fries.
A #12 scoop (80 ml) was used for the minced coleslaw.
Staff ran out of fish, French fries and coleslaw and had to go to another home area for additional portions. They returned and stated they were unable to get more fish.
A second staff stated "they were always running out of food and did not make enough when it was a meal that everyone liked".

A third meal service was observed.
Staff stated the home served a barbeque for the residents every Wednesday in different home areas but did not have a therapeutic menu that indicated the portion sizes for the different menu items.
The home's policy, Portion Control, identified that dietary aides were responsible to follow the therapeutic menus to ensure proper portioning and to follow the portion sizes for each diet.

A consultant confirmed the expectation that staff followed the therapeutic menu, including the tools indicated and confirmed that if staff used different tools, it would likely not provide the appropriate portion size.
Failure to provide the portion sizes as outlined in the therapeutic menu resulted in residents not receiving planned menu items as intended.

Sources: Meal observations**;** Spring/Summer 2022 Therapeutic Menu, Portion Control Policy; interviews with a resident and staff. [720920]

WRITTEN NOTIFICATION – INFECTION PREVENTION AND CONTROL

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
The licensee has failed to ensure the implementation of any standard, or protocol issued by the Director with respect to infection prevention and control, specifically that the infection prevention and control program included policies and procedures to support residents with hand hygiene prior to receiving meals.

Rationale and Summary
Section 10.4 (h) and (i), of the Infection Prevention and Control Standard for Long-Term Care Homes identified the hand hygiene program shall include policies and procedures to support

residents to perform hand hygiene prior to receipt of meals, including those who have difficulty to complete hand hygiene due to mobility, cognitive or other impairments. The home's Hand Hygiene policy stated that residents would be encouraged and/or assisted to perform hand hygiene prior to meals.

O. Reg 246/22 s. 11 (1) (b) required that the licensee ensured the policy was complied with.

i. Residents observed were not encouraged, offered, or assisted with hand hygiene prior to being served their meal.
ii. On two different dates residents who entered the dining room were not encouraged, offered, or assisted with hand hygiene prior to being served their meal.

Staff acknowledged they had not encouraged, offered, or assisted residents with hand hygiene prior to delivery of their lunch tray.

Management staff confirmed that support to residents to perform hand hygiene prior to meals was the home's expectation.

Failure to ensure staff supported residents with hand hygiene in accordance with the home's Hand Hygiene policy and the IPAC Standard may have increased the risk of transmission of disease-causing or infectious organisms.

Sources: Observations; Hand Hygiene; interviews with staff. [720920]

WRITTEN NOTIFICATION – INFECTION PREVENTION AND CONTROL PROGRAM

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

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

The licensee has failed to ensure that there was an outbreak management system in place that included reporting protocol based on requirements under the Health Protection and Promotions Act, specifically reporting to the medical officer of health of the health unit in which the institution was located that a person had or might have had a disease of public health significance as soon as possible after the entry was made in the records of the institution.

Rationale and Summary

The home's policy, Communicating During an Outbreak, identified there was to be a process that facilitated early communication with external stakeholders and the IPAC lead or designate was responsible to contact Public Health.

The Critical Incident (CI) report submitted identified a resident was symptomatic and sent to the hospital. The following day the home was notified of the resident's diagnosis, a disease of public health significance.

Approximately two days later Public Health was contacted about the diagnosis and an outbreak was declared.

Public health staff confirmed the home could have used the online reporting portal system which was available and monitored on weekends. They stated had it been reported when the home was first informed, the outbreak and high-risk contacts could have been identified sooner.

Management staff identified they did not have a clear process to contact public health on weekends or statutory holidays and the expectation that home's nurse manager or on-call manager would notify public health when the IPAC lead was not onsite.

Failure to notify public health initially with the positive test results may have contributed to the spread of the virus to other residents and/or staff.

Sources: CI report, Communicating During an Outbreak; interviews with staff. [720920]

WRITTEN NOTIFICATION – REPORTING AND COMPLAINTS

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 108 (2)

The licensee has failed to ensure that there was a documented record for a complaint including the nature of the verbal complaint; the type of action taken to resolve the complaint, which included the date of the action, time frames for actions to be taken, any follow-up action required; the final resolution; every date on which any response was provided to the complainant, a description of the response; and any response made in turn by the complainant.

Rationale and Summary

A complaint was received and documented on a Complaint Investigation Form.

The form did not include the follow-up action taken; the final resolution; every date on which any response was provided to the complainant, a description of the response; and any response made in turn by the complainant.

The Complaint Log did not include an entry related to the complaint.

Failure to maintain a record of complaints as required increased the potential for additional complaints and inconsistent actions to resolve concerns.

Sources: A review of the clinical record for a resident including assessments, progress notes and care plan; review of the Complaint Log and completed Complaint Investigation Forms and interview with staff. [168]

WRITTEN NOTIFICATION – REPORTING AND COMPLAINTS

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 108 (3) (a)

The licensee has failed to ensure the documented record of complaints was reviewed and analyzed for trends at least quarterly.

Rationale and Summary

The home was unable to provide a current quarterly review or analysis of the record of complaints.

Staff identified that there was no current quarterly review or analysis of complaint records.

Sources: Interview with staff. [168]

WRITTEN NOTIFICATION – REPORTING AND COMPLAINTS

NC #020 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 115 (1) 5

The licensee has failed to ensure that the Director was immediately informed when an outbreak of a disease of public health significance occurred in the home, specifically an outbreak.

Rationale and Summary

A CI report submitted to the Director indicated that public health declared an outbreak.

The report was submitted approximately two days later.

Management staff acknowledged that the form was submitted late and stated they did not have access to the CI system prior.

Sources: CI report; interviews with staff. [720920]

WRITTEN NOTIFICATION – ADMINISTRATION OF DRUGS

NC#021 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use as specified by the prescriber.

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Hamilton ON L8P 4Y7
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Rationale and Summary

A resident was prescribed a medication, to be given twice a day for one week. The order was changed later that same day to administer another medication twice a day instead of the initial medication.

According to the eMAR staff administered an additional dose of the first medication despite the new order and change in directions for use by the prescriber.

The resident was not started on the second medication until the following day during the evening after it was prescribed.

Sources: Review of physician's orders and eMAR for a resident and interview with staff. [168]