Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 10, 2021	2021_823653_0019	005978-21	Critical Incident System

Licensee/Titulaire de permis

King Nursing Home Limited
49 Sterne Street Bolton ON L7E 1B9

Long-Term Care Home/Foyer de soins de longue durée

King Nursing Home
49 Sterne Street Bolton ON L7E 1B9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ROMELA VILLASPIR (653)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 28, 29, 30, 2021.

The following intake was completed in this CIS inspection:
Log #005978-21 was related to an allegation of resident abuse.

During the course of the inspection, the inspector(s) spoke with the residents, Resident Care Aides (RCAs), Personal Support Workers (PSWs), Agency Staff, Registered Practical Nurses (RPNs), Registered Nurses (RNs), Behavioural Support Ontario (BSO) RPN, Infection Prevention and Control (IPAC) Lead, Housekeepers (HKs), Environmental Service Manager (ESM), and the Director of Care (DOC).

During the course of the inspection, the inspector toured the home, observed IPAC practices, provision of care, resident to resident interaction, reviewed clinical health records, staffing schedules, the home's surveillance testing records, air temperature records, the home's investigation notes, staff training records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that an incident of alleged resident abuse was immediately reported to the Ministry of Long-Term Care (MLTC).

Pursuant to s. 24 (1) 2, the licensee is vicariously liable for staff who fail to report abuse.

On an identified date and time, an incident occurred between two residents which resulted in physical injuries. The incident was not witnessed, however, the staff alleged that abuse may have taken place. Registered Nurse (RN) #100 did not immediately report the incident to the on-call manager, but passed on the information to RN #102. Ten hours after the incident happened, the Director of Care (DOC) became aware of the alleged abuse after reading RN #102's e-mail correspondence which contained a report of the incident.

As a result of the staff not reporting the incident of alleged abuse to the MLTC immediately, the MLTC was unable to respond to the incident immediately, which may have put the two residents at risk of harm.

Sources: Review of Infoline report, CIS report; Interviews with RCA #104, RNs #100, #102, and the DOC. [s. 24. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur, shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home, and one resident common area on every floor of the home at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

A) A review of the home's air temperature records for May, and June 2021, revealed that the temperatures in at least two resident bedrooms in different parts of the home, were not measured nor documented in writing at the required specified times, on the following dates: May 15-31, 2021, and June 1-9, 2021.

B) A review of the home's air temperature records for May, June, and July 2021, revealed that the temperature in one resident common area on every floor of the home, was not measured nor documented in writing at the required specified times, on the following dates: May 15-31, June 1-9, July 13-16, July 18,-25, July 27-28, 2021.

C) A review of the home's Air Temperature Log Form – Maintenance from June 1, inclusive to July 28, 2021, revealed incomplete documentation of air temperatures on the following dates: June 15-20, 23, 26-27, and July 3, 4, 9, 11, 2021.

The Environmental Service Manager (ESM) acknowledged that the home's air temperature records failed to demonstrate compliance with the temperature measurement and documentation requirements set out in the legislation. By not measuring and documenting the required air temperatures at a minimum in at least two resident bedrooms in different parts of the home, and one resident common area on every floor of the home, at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night, staff may not be able to ascertain and address temperature concerns. This could put residents at risk for developing a heat related illness.

Sources: Review of the home's air temperature records; Interview with the ESM. [s. 21. (3)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to ensure that the appropriate police force was immediately notified of the alleged incident of resident abuse, that the licensee suspected may have constituted a criminal offence.

On an identified date and time, an incident occurred between two residents which resulted in physical injuries. The incident was not witnessed, however, the staff alleged that abuse may have taken place. RN #100 did not immediately report the incident to the on-call manager, but passed on the information to RN #102. Ten hours after the incident had taken place, RN #102 notified the police authorities, after they were instructed by the DOC.

There was minimal risk of harm to the two residents related to the late notification of the incident to the police.

Sources: Review of the CIS report; Interviews with RCA #104, RNs #100, #102, and the DOC. [s. 98.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 174.1 Directives by Minister

Specifically failed to comply with the following:

s. 174.1 (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. 2017, c. 25, Sched. 5, s. 49.

Findings/Faits saillants :

1. The licensee has failed to comply with the Minister's Directive (MD): COVID-19: Long-Term Care Homes (LTCH) Surveillance Testing and Access to Homes, effective July 16, 2021, when two agency staff were not tested for COVID-19, but were allowed into the LTCH to work.

As per the MD COVID-19: LTCH Surveillance Testing and Access to Homes: In relation to individuals who were not fully immunized, and with respect to every LTCH that were not experiencing an outbreak of COVID-19, every licensee shall ensure that subject to the exceptions of the directive, as applicable, all staff, caregivers, student placements and volunteers working in or visiting a LTCH take one PCR test and one antigen test on separate days within a seven-day period. At a minimum, where a staff, caregiver, student placement or volunteer enters a LTCH only once within a seven-day period, the licensee shall ensure that the staff, caregiver, student placement or volunteer takes an antigen test on that day.

A review of the home's active screening tool for COVID-19, rapid antigen, and PCR testing records, showed that Agency Personal Support Worker (PSW) #119 and Agency RCA #120 were not tested for COVID-19, but were allowed into the LTCH to work. The home's IPAC Lead was unable to provide proof of documentation that could demonstrate that both agency staff were tested for COVID-19 as required by the most current and applicable MD.

Due to the home's non-compliance with the testing requirements, there was a potential risk for exposure to COVID-19 from the agency staff.

Sources: Review of the MD: COVID-19: LTCH Surveillance Testing and Access to Homes, effective July 16, 2021, the home's active screening tool for COVID-19, rapid antigen, and PCR testing records; Interview with the IPAC Lead. [s. 174.1 (3)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff participated in the implementation of the home's Infection Prevention and Control (IPAC) program.

A review of the home's LTC Infection Prevention & Control policy, stated that team members will perform hand hygiene using alcohol-based hand rub:
-After contact with a resident's intact skin
-Before donning gloves
-Before entering a resident's room
-Before exiting a resident's room

The following observations were conducted by Inspector #653:
-RN #105 entered the home area from the exit stairwell, then proceeded to a resident's room without performing hand hygiene. The RN stayed inside the room and performed wound dressing treatment for a resident.
-RN #105 exited from the resident's room without performing hand hygiene, walked to the common area and asked Agency PSW #106 to assist them with turning the resident. RN #105 and Agency PSW #106 entered the room without performing hand hygiene. Shortly after the assistance was provided, Agency PSW #106 doffed their gloves, disposed them in the garbage bin, and exited the room without performing hand hygiene.
-Following care provision, Agency PSW #107 exited from a resident's room without performing hand hygiene, and proceeded to another resident's room.
-After completing the wound dressing treatment for a resident, RN #105 exited from the resident's room without performing hand hygiene.

There was a potential risk for transmission of infection due to the lack of hand hygiene by the staff.

Sources: Review of the home's LTC Infection Prevention & Control policy; Inspector #653's observations; Interviews with RN #105, Agency PSWs #106, #107, and the IPAC Lead. [s. 229. (4)]

Issued on this 10th day of August, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.