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

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

Original Public Report

Report Issue Date September 2, 2022
Inspection Number 2022_1495_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Knollcrest Lodge

Long-Term Care Home and City
Knollcrest Lodge
50 William Street, Milverton, Ontario, N0K 1M0

Lead Inspector
Tatiana Pyper (733564)

Additional Inspector(s)
Debbie Warpula (577)

Inspector Digital Signature
Tatiana Pyper
Digitally signed by Tatiana Pyper
Date: 2022.09.02 10:53:36 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 8, 9, 10, 11, and 12, 2022.

The following intake(s) were inspected:

- Intake #002061-22 (CIS# 2996-000002-22) related to falls prevention and management.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)

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INSPECTION RESULTS

WRITTEN NOTIFICATION SKIN AND WOUND CARE

NC#001 Written Notification pursuant to LTCHA, 2007

Non-compliance with: O. Reg. 79/10 s.50 (2) (b) (iii)

The licensee has failed to ensure that a referral was sent to the Registered Dietitian (RD) for an assessment, when a resident exhibited altered skin integrity after they sustained a fall.

Rationale and Summary
A resident sustained a fall, resulting in significant change in health and hospitalization. Review of the resident's clinical notes indicated that a referral to the RD was not made after the resident sustained a fall.

During an interview with the RD, it was indicated by them that a referral was not sent to them for an assessment of the resident, after they sustained a fall, when the resident exhibited altered skin integrity.

During an interview with the Director of Care (DOC), it was indicated by them that a referral to the RD was not sent after the resident sustained a fall. The DOC indicated that the expectation of the home was that a referral to the RD was to be made for a resident exhibiting altered skin integrity.

The RD not having received a referral for an assessment of the plans of care for the resident to promote wound healing, after resident exhibited altered skin integrity, created risk for potential delayed skin healing.

Sources: review of resident's clinical records, interview with the RD, and the DOC.

[#733564]

WRITTEN NOTIFICATION SKIN AND WOUND CARE

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

Non-compliance with: O. Reg. 246/22 s.55 (2) (b) (iii)

The licensee has failed to ensure that a referral was sent to the Registered Dietitian (RD) for an assessment, when a resident exhibited altered skin integrity after they sustained a fall.

Rationale and Summary

A resident sustained a fall resulting in an area of altered skin integrity.

Review of the resident's clinical notes indicated that a referral to the RD was not made after the resident sustained a fall.

During an interview with the RD, it was indicated by them that a referral was not sent to them for an assessment of the resident, after they sustained a fall, when the resident exhibited altered skin integrity.

During an interview with the Director of Care (DOC), it was indicated by them that a referral to the RD was not sent after the resident sustained a fall. The DOC indicated that the expectation of the home was that a referral to the RD was to be made for a resident exhibiting altered skin integrity.

The RD not having received a referral for an assessment of the plans of care for the resident to promote wound healing, after resident exhibited altered skin integrity, created risk for potential delayed skin healing.

Sources: review of resident's clinical records, interview with the RD, and the DOC.

[#733564]

COMPLIANCE ORDER [CO#001] PLAN OF CARE

NC#003 Compliance Order pursuant to LTCHA, 2007, s.154(1)2
Non-compliance with: LTCHA, 2007 s.6 (7)

The Inspector is ordering the licensee to:
FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

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Compliance Order [FLTCA 2021, s. 155 (1)]

The licensee has failed to comply with **LTCHA, 2007** s. 6 (7).

Specifically, the licensee must ensure:

A) The resident's falls prevention interventions are to be in place as per their plan of care.

B) Conduct daily audits for 30 days to ensure that the resident's falls preventions interventions are in place as per their care plan daily and record the result of the daily audits in the resident's clinical notes.

Grounds

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

Rationale and Summary

A Critical Incident System (CIS) report was received by the Director, after a resident sustained a fall that resulted in hospitalization, and a significant change in the resident's health status.

The resident's plan of care indicated that they were to have falls prevention interventions in place.

Post fall assessment completed for the resident, indicated that possible contributing factor to their fall was that the fall preventions interventions were not in place.

In an interview, a Personal Support Worker (PSW) indicated that the resident required fall prevention and management strategies.

The fall prevention interventions not being in place allowed for potential risk of falls for the resident.

Sources: review of resident's clinical records, interview with a PSW.

[#733564]

This order must be complied with by September 30, 2022

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WRITTEN NOTIFICATION PLAN OF CARE

NC#004 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 care set out in the plan of care was provided to the resident as specified in their plan of care.

Rationale and Summary

A Critical Incident System (CIS) report was received by the Director, after a resident sustained a fall that resulted in hospitalization, and a significant change in the resident's health status.

i) During a record review of the resident's progress records, Inspector #733564 reviewed a progress note that indicated that the resident was without their fall prevention interventions in place on a specific date.
The resident's plan of care indicated that there were required to have fall prevention interventions in place. On a specific date, a Registered Practical Nurse (RPN) noted the resident's fall prevention interventions were not in place.

ii) During a record review of the resident's progress records, Inspector #733564 noted the resident sustained falls on additional dates.
The resident's plan of care indicated that they were at high risk for falls.

In an interview, the RPN indicated that the resident was without their fall prevention interventions on a specific date.

The home failed to reduce the risk of injury for the resident from falls, by not having the fall prevention interventions in place for the resident for several hours a specific date, as per the resident's plan of care.

Sources: review of CIS report, resident's plan of care, resident's clinical records, interview with the RPN.

[#733564]

COMPLIANCE ORDER [CO#002] INFECTION PREVENTION AND CONTROL PROGRAM

NC#005 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 102 (8)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The licensee has failed to comply with **O. Reg. 246/22** s. 102 (8).

Specifically, the licensee must ensure:

A) Screeners receive training on IPAC, including, but not limited to, hand hygiene (HH), donning and doffing Personal Protective Equipment (PPE), and PPE requirements for performing a rapid antigen test.
B) The PSW receives retraining on IPAC, including but not limited to, hand hygiene, and contact precautions.
C) The Administrative Assistant, the DOC, and the Life Enrichment Manager receives training on IPAC, including but not limited to physical distancing.
D) Complete weekly IPAC audits related to HH, masking, physical distancing, appropriate use of PPE when performing rapid antigen tests and resident hand hygiene prior to meals and snacks. The audits must be completed for eight weeks.
E) Maintain a record of the audits and actions taken based on the audit results.
F) Screeners receive retraining on IPAC training, including but not limited to active screening and surveillance testing.
G) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainers, and materials taught.
H) Complete weekly IPAC audits related to active screening and surveillance testing of visitors and staff into the home for 60 days.

Grounds

The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control (IPAC) program.

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Rationale and Summary:

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act.

On April 27, 2022, Minister's Directive: COVID-19 response measures for long-term care homes were issued to all Long-Term Care Homes (LTCHs) pursuant to s. 184 (1) of the Fixing Long-Term Care Act, 2021 (Act). The directive related to the safe operation of LTCHs, specifically to reduce the risk of COVID-19. LTCHS were to practice the health and safety requirements contained in the directive which included masking, physical distancing, and personal protective equipment (PPE) requirements.

A) Review of the home's policy "Pandemic (Covid-19) Screening" noted "The screener will wear the full PPE at all times (gown, gloves, mask, goggles, closed toe shoes) while screening, (exception: may remove mask/place on clean surface for rehydration while maintaining 6-foot physical distance). "

i) A Screener was observed not wearing all required PPE, while completing active screening for visitors and staff.

ii) A Screener was observed screening more than one visitor at a time, without completing all the steps required during the active screening of visitors and staff into the home, including performing hand hygiene at required timeframes while completing rapid antigen testing.

In an interview, the Screener acknowledged they did not wear appropriate PPE when they screened visitors and staff into the home, and when they performed the rapid antigen tests. The Screener stated that they do not always perform hand hygiene in between steps required during screening and performing the rapid antigen testing.

In an interview, the Infection Prevention and Control (IPAC) Lead stated that the screeners were to wear a surgical mask and gloves when handling the rapid antigen tests and perform hand hygiene in between steps. The IPAC Lead stated that visitors and staff should be screened one at the time.

B) Minister's Directive: COVID-19 response measures for long-term care homes states that licensees are required to ensure that the physical distancing requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, are followed.

The COVID-19 Guidance Document for Long-Term Care Homes in Ontario updated June 11, 2022, states that homes must ensure that physical distancing (a minimum of two meters or six feet) is practiced by all individuals at all times.

i) The Administrative Assistant, the DOC, and the Life Enrichment Manager were observed sitting without PPE within less than six feet from each other, while consuming their lunch.

In an interview, the Administrator stated that staff members are expected to be six feet apart while eating or drinking in their designated area.

C) The IPAC Standard for Long-Term Care Homes dated April 2022, states the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include the use of infectious disease risk assessments including point of care risk assessments; and HH, including, but not limited to, at the four moments of HH (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

i) The PSW not wearing all required PPE was observed providing direct care to a resident who was on specific additional precautions.

The PSW acknowledged that they were to wear full PPE, which included a mask, gown, eye protection, and gloves, when providing care to the resident.

The IPAC Lead stated that staff members who were providing direct care to a resident on specific additional precautions should be wearing full PPE.

The Public Health Inspector stated that staff members who were providing direct care for a resident who was on isolation were to wear full PPE, including mask, gown, eye protection and gloves.

D) Minister's Directive: COVID-19 response measures for long-term care homes states that licensees are required to ensure that the COVID-19 screening requirements as set out in the COVID-19 Guidance Document for Long-Term Care Homes in Ontario, or as amended, are followed.

On August 9, 2022, a Screener was observed screening more than one visitor at one time. Inspector #733564 observed the first visitor screened with active screening questions into the home. The Inspector observed the Screener permit second and third visitor to enter the home without asking the screening questions required during the active screening of visitors and staff into the home.

In an interview, the Huron Perth Public Health Inspector stated that screeners not following the active screening protocols did not meet the infection control expectations.

Review of the home's policy "Pandemic (Covid-19) Screening noted "Screening is to take place at the doors in the main entrance of the building PRIOR to entry. When multiple persons are waiting to be screened, a physical distancing of 6 feet will be maintained."

Sources: Observations of IPAC practices in the home, observations of the home's active screening processes, review of the IPAC Standard for Long-Term Care Homes dated April 2022, review of Minister's Directive: COVID-19 response measures for long-term care homes effective April 27, 2022, COVID-19 Guidance Document for Long-Term Care Homes in Ontario updated June 11, review of the home's policy "Pandemic (Covid-19) Screening" policy effective February 2022, interview with the Screener, the IPAC Lead, the Huron Perth Public Health Inspector, and the Administrator.

[733564]

This order must be complied with by October 28, 2022

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

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

Non-compliance with: O. Reg. 246/22 s. 102 (15) (2)

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Lead designated under this section worked regularly in that position on site at the home for at least 26.25 hours per week.

Rationale and Summary

Section 102 (15) of the Ontario Regulation 246/22 specified a home, with a licensed bed capacity of more than 69 beds but less than 200 beds, was required to have a designated IPAC lead who worked regularly on site at the home for a minimum of 26.25 hours a week.

The home had greater than 69 bed capacity, and therefore met the 26.25 hours per week requirement.

The IPAC Lead stated that were not working for a set number of hours in their role, and they could not attest that they spent the minimum of 26.25 hours per week requirement in their IPAC Lead role.

The home not having a designated IPAC Lead whose primarily responsibility was the home's IPAC program impacted the home's IPAC program, as evidenced by the multiple IPAC non-compliances observed in the home.

Sources: Interview with the IPAC Lead.

[#733564]

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

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

Non-compliance with: O. Reg. 246/22 s. 102 (4) (e)

The licensee has failed to ensure that the IPAC program was evaluated and updated at least annually, in accordance with the standards and protocols issued by the Director under subsection (2).

Rationale and Summary

Section 102 (4) (e) of the Ontario Regulation 246/22 specified that the IPAC program is required to be evaluated and updated at least annually, in accordance with the standards and protocols issued by the Director under subsection (2).

A letter from the IPAC Consulting company, stated the home's IPAC program review had been completed.

The IPAC Lead stated that the last time the IPAC program was reviewed was on March 25, 2021, by IPAC Consulting company. The IPAC Lead stated that the IPAC program not being evaluated annually did not meet the expectations of the legislation.

The home not having the IPAC Program evaluated annually has impacted the home's IPAC program, as evidenced by the multiple IPAC non-compliances observed in the home.

Sources: Interview with the IPAC Lead, letter from IPAC Consulting, and the home's "Infection Control" Policy, effective date May 2022.

[#733564]

WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

NC#008 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 that the interdisciplinary infection prevention and control team meets at least quarterly and on a more frequent basis during an infectious disease outbreak in the home.

Rationale and Summary

Section 102 (2) (b) of Ontario Regulations 246/22 specifies that the licensee shall implement any standard or protocol issued by the Director with respect to infection prevention and control.

The IPAC Standard for Long-Term Care Homes dated April 2022, states the licensee is required to ensure that the interdisciplinary infection prevention and control team meets at least quarterly and on a more frequent basis during an infectious disease outbreak in the home.

Review of the home's "Infection Control Policy" noted that IPAC meetings should have been held at least quarterly, and on more frequent basis during an infectious disease outbreak in the home.

The IPAC Lead stated that IPAC meetings had not occurred for over one year. The IPAC Lead stated that the last IPAC meeting was held in June 2021. The IPAC Lead stated that the IPAC program meetings not being held at least quarterly, did not meet the expectations of the home's policy.

The home not having IPAC Program meet at least quarterly has impacted the home's IPAC program, as evidenced by the multiple IPAC non-compliances observed in the home.

Sources: review of IPAC Standard for Long-Term Care Homes dated April 2022, interview with the IPAC Lead, review of IPAC minutes dated August 8, 2021, and the home's "Infection Control Policy", effective date May 2022.

[#733564]

WRITTEN NOTIFICATION TRAINING

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

Non-compliance with: FLTCA, 2021 s. 82 (2) (9)

The licensee has failed to ensure that Screeners had received training on active screening prior to performing their duties.

Rationale and Summary

In August 2022, a Screener was observed screening more than one visitor at one time. Inspector #733564 observed the first visitor screened with active screening questions into the home. The Inspector observed the Screener permit second and third visitor to enter the home without asking the screening questions required during the active screening of visitors and staff into the home.

In an interview, the Screener stated that they did not receive training on active screening.

In an interview, the Huron Perth Public Health Inspector stated that screeners not following the active screening protocols does not meet the infection control expectations.

Review of the home's policy "Pandemic (Covid-19) Screening noted "Screening is to take place at the doors in the main entrance of the building PRIOR to entry. When multiple persons are waiting to be screened, a physical distancing of 6 feet will be maintained."

In an interview, the IPAC Lead stated that they were unable to locate any documentation to support that the Screener and the Screener had received training on active screening.

Sources: Interview with the Screener, the IPAC Lead, the Huron Perth Public Health Inspector.

[#733564]

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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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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).

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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
email: 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.