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

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Original Public Report

Report Issue Date: October 18, 2023	
Inspection Number: 2023-1495-0004	
Inspection Type: Proactive Compliance Inspection	
Licensee: Knollcrest Lodge	
Long Term Care Home and City: Knollcrest Lodge, Milverton	
Lead Inspector Nuzhat Uddin (532)	**Inspector Digital Signature** Helene Desabrais Digitally signed by Helene Desabrais Date: 2023.10.25 15:29:45 -04'00'
Additional Inspector(s) JanetM Evans (659)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 19-22, 25-29, 2023.

The following intake(s) were inspected:

- Intake: #00096867 - Proactive Compliance Inspection

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

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Quality Improvement
Pain Management
Falls Prevention and Management
Skin and Wound Prevention and Management
Resident Care and Support Services
Residents' and Family Councils
Infection Prevention and Control

Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (3)

The licensee failed to make every reasonable effort to act on the results of the 2022 Residents' survey and to improve the long-term care home and the care, services, programs and goods accordingly.

Rationale and Summary

A survey of residents and families was completed December 2022. There were multiple concerns identified in the survey related to the care of residents.

None of the concerns identified from the 2022 survey, were documented in the home's Annual quality improvement (CQI) plan 2022/2023, nor were they documented in the home's 2023/2024 Quality Improvement Plan for Ontario Long Term Care Homes "Improvement Targets and Initiatives".

The home was not able to provide documentation that any of the identified concerns from the survey had been implemented.

The CEO acknowledged the home had not acted on the results of the survey.

Failure to make every reasonable effort to act on the results of the 2022 Residents' survey misses an opportunity to work collaboratively to implement care, services or improvements that would enhance their satisfaction with operations of the home.

Sources: Annual quality improvement (CQI) plan 2022/2023, 2023/24 Quality Improvement Plan for Ontario Long Term Care Homes "Improvement Targets and Initiatives" (HQO). Interviews with CEO, Life Enrichment manager, Family council attendees.

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WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (4)

The licensee failed to seek the advice of the Residents' Council and the Family Council, in carrying out the survey and in acting on its results.

Rationale and Summary

A survey of residents and families was completed December 2022.

The Family Council did not recall the licensee seeking the advice of the council in carrying out the survey or acting on its results.

The CEO said the Councils advice was not sought in carrying out the survey and acting on its results.

Failure to seek Residents' or Family Councils advice in carrying out the survey and acting on its results is a missed opportunity to liaise with the Councils for input as to areas of importance the Councils would like addressed.

Sources: Annual quality improvement (CQI) plan 2022/2023, 2023/24 Quality Improvement Plan for Ontario Long Term Care Homes "Improvement Targets and Initiatives" (HQO). Interviews with CEO, Life Enrichment Manager, Family Council.

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WRITTEN NOTIFICATION: Orientation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2)

The licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 28 to make mandatory reports.
5. The protections afforded by section 30.
6. The long-term care home's policy to minimize the restraining of residents.
Note: On a day to be named by proclamation of the Lieutenant Governor, paragraph 6 of subsection 82 (2) of the Act is amended by striking out "restraining" and substituting "restraining and confining". (See: 2021, c. 39, Sched. 1, s. 203 (16))
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

Rationale and Summary

A) The licensee provided agency staff with an orientation checklist to sign and return to the home. In addition, agency staff were to sign off that they had completed a review of the Agency Handbook and Mandatory Education with Direct Care staff addendum.

An agency staff did not recall having received the Agency Handbook and Mandatory Education when they were shown the book. They were not able to recall completing mandatory trainings prior to working at the home.

The Financial and Business Manager (FBM) stated agency staff were supposed to come to the home trained, but sometimes the agency would substitute and send non trained staff.

B) Online learning for a Registered staff showed orientation trainings were not completed prior to working at the home, rather they were completed over a 4-5 month period.

The FBM said some staff come to the home with their training already completed, some come and do it during their orientation shift when they are buddied with another staff member.

C) Online learning documentation showed a dietary staff had not completed mandatory training on zero tolerance of abuse and neglect, but had completed other required training over the first two weeks of their hire.

Failing to provide mandatory training prior to staff performing their responsibilities puts the staff at risk for not understanding the expectations and how to deal with certain situations and puts the residents at potential risk of harm.

Sources: Surge learning, Agency employee orientation checklist, Agency Handbook and Mandatory Education with Direct Care.

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WRITTEN NOTIFICATION: General requirements for programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.

The licensee has failed to ensure that the skin ad wound care program was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Rationale and Summary

No records were provided related to the annual Skin and Wound care program evaluation.

The Director of Resident Care acknowledged that there was no written record of the skin and wound program evaluation.

Sources: no written record of the Home's annual program evaluation record, for skin and wound program, and interview with the DRC.

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WRITTEN NOTIFICATION: General requirements

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.

The licensee has failed to ensure that there was a written record of the programs' evaluation that included the names of the persons who participated in the evaluation, and a summary of changes that were made, and the date that the changes were implemented.

Rationale and Summary

The home completed their annual evaluations for the falls prevention program dated March 9, 2022, and the pain program gap analysis completed on July 12, 2022.

Neither program evaluation included a date of when the summary of changes was implemented.

September 26, 2023, the Director of Resident Care acknowledged that there were no dates for when the changes were implemented.

Sources: Home's annual program evaluation record, for Falls prevention program, date reviewed: March 9, 2022 and Pain date reviewed July 12, 2022ecember 2022, and interviews with the DRC.

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WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (a)

The licensee has failed to ensure that the nutritional care and dietary services program was implemented.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is an organized program of nutritional care and dietary services including the implementation of policy of the home, specifically that meal service is complied with.

The home's "Pleasurable Dining with Dignity" policy (last reviewed September 1, 2023) specified that members of the interdisciplinary care team work closely together to address residents' nutrition and hydration needs and to create a pleasurable dining experience.

Rationale and Summary

During observations in the specified dining room, nursing staff were not available to serve the residents as per posted mealtimes.

A resident expressed a concern over waiting for an extended period of time. A Substitute Decision Maker (SDM) stated that residents in the specified dining room do not get their first course until a later time than expected.

During a food committee meeting and the Resident Satisfaction survey summary also identified that long wait times in the dining room was a concern.

During two observations, residents waited approximately 26 to 30 minutes before the main course was served.

The CEO stated that pleasurable dining was part of their home's action plan as it was identified as a concern through their own observations.

The residents and family were concerned when staff took long to serve and were not able to participate in the dining service by the posted meal times making the dining service an uncomfortable and unpleasant experience for the residents.

Sources: "Pleasurable Meal Service Strategies" policy reviewed September 1, 2023, , interview with a resident, a SDM, the DOC and the CEO.

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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 (10)

The licensee failed to ensure that the information gathered under subsection (9) was reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

Rationale ad Summary

The home's IPAC policy said the Infection Control Designate (ICD) was to analyze surveillance data with the Infection control committee (ICC) to evaluate if any IPAC practices needed to be altered and report trends and recommendations to be taken.

The home's process was to track and record respiratory or gastrointestinal symptoms on a line listing report but all other signs and symptoms of infection were recorded in the individual resident progress note records.

No documentation was provided to show that a review of the monthly surveillance was completed to detect trends from the information collected under O. Reg. 246/22 s. 102 (9).

The IPAC lead said they had not reviewed the information collected under subsection (9) a minimum of monthly to determine trends, rather they reviewed the information quarterly at the Professional Advisory Committee (PAC).

Failure to review the information collected under subsection (9) a minimum of monthly may prevent the home's ability to identify and respond to trends in a timely fashion to reduce the incidence of further infection and outbreaks.

Sources: 2021-2022 IPAC Policy Manual for Knollcrest Lodge, interview with Infection Prevention and Control (IPAC/ICD) lead.

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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 failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

Rationale and Summary

IPAC standard #3 related to surveillance, directed the home to ensure that common forms and tools were available for surveillance reporting, ensure a surveillance database and reporting tool were used in the home to collect and collate data and ensure surveillance information was tracked and entered into the database and/or reporting tools.

The home's procedure for surveillance directed staff to document resident symptoms on a line list and that the Infection Control Designate (ICD) would review this data daily.

An RN stated that the home only recorded respiratory symptoms and gastrointestinal (GI) symptoms using a line list. All other resident symptoms of infection (ie. Urinary, skin, eye and etc) were recorded in the resident's progress notes in Point Click care.

The IPAC lead stated the home had access to an infection prevention and control database but had not yet implemented this.

Failure to utilize a surveillance database and/or reporting tool to collect and collate surveillance data is a risk to the home for early identification and management of resident infections.

Sources: IPAC Standard for Long-Term Care Homes dated April 2022, 2021-2022 Infection Prevention and Control Manual for Knollcrest Lodge, interviews with the IPAC lead and staff.

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WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 4.

The licensee failed to ensure that a written description of the process to monitor and measure progress, identify and implement adjustments and communicate outcomes for the identified priority areas for quality improvement for the next fiscal year were included in the their annual quality improvement report (CQI) 2022/23.

Rationale and Summary

The licensee's website had a copy of their annual CQI report 2022/23 posted. As well they had posted a QI Narrative and QI workplan related to Health Quality Ontario initiatives.

The annual CQI report documented that work on quality improvement would be active and their operational initiatives for 2023/24 included:
1. Welcoming a new permanent CEO,
2. Bringing our CQI Committee up to a mature level of functioning and oversight,
3. Looking to add a robust Quality and Risk Management software application to our electronic health record system.

As well, it indicated the home was seeking accreditation April 2024.

No written descriptions of the processes the home would use to monitor and measure progress, identify and implement adjustments or communicate outcomes for the identified priority areas were noted in the annual CQI report specific to the above initiatives.

The CEO stated they had not been involved in the documentation of the annual CQI report 2022/23.

Failing to document descriptions of the processes the home would use to monitor and measure progress, identify and implement adjustments or communicate outcomes for the identified priority areas put the home at risk for inconsistencies in interpretation of their CQI data, communication strategies and outcomes.

Sources: 2022/23 Annual CQI Report, interview with CEO

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WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative report

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5.

The licensee failed to ensure that the written record of the home's CQI report posted to their website included:
i. the date the survey required under section 43 of the Act was taken during the fiscal year,

ii. the results of the survey taken during the fiscal year under section 43 of the Act, and
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

Rationale and Summary

A written annual continuous quality improvement (CQI) report dated 2022/23 was posted to the homes website.

The required information as listed above was not documented in the Annual CQI report 2022/23.

The CEO stated they were not involved in the development of the CQI report.

Failing to document the information listed above, related to the survey required under section 43 of the Act in the CQI reported posted to the home's website was a missed opportunity to ensure timely and consistent dissemination of the information to all residents, their families, Council members, and staff of the home.

Sources: Home's website, 2022/23 Annual CQI Report, interview with CEO.

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WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6.

The licensee failed to ensure the report required under subsection (1) contained the following information:
A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided

to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,
iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii,
iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

Rationale and Summary

A written annual continuous quality improvement (CQI) report dated 2022/23 was posted to the homes website. The report did not include any information related to i, iii, iv or v. The CQI report did list 27 other actions and in some instances had listed months or the year when some of the items were implemented but there was only one instance when an outcome of an action was documented.

Failure to include all required information as listed above in the written CQI report is a missed opportunity to track and share the home's progress with residents and their families and staff, related to all actions taken to improve the long-term care home, and the care, services, programs and goods and outcomes from year to year.

Sources: 2022/23 Annual CQI report.

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WRITTEN NOTIFICATION: Continuous Quality Improvement Initiative Report

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)

The licensee failed to ensure that a copy of the CQI report was provided to the Residents' Council and Family Council.

Rationale and Summary

Minutes from the May to Aug 2023 Residents' Council meetings and the March to May 2023 Family Council meetings were reviewed. There was no documentation that the CQI report had been shared with the Councils.

The CEO acknowledged the CQI report had not been shared with either Council and said they had been waiting to share this when they had their CQI meeting.

Sources: Residents and Family Council meeting minutes, interview with the CEO.

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WRITTEN NOTIFICATION: additional training-direct care staff

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1)

The licensee has failed to ensure that training was provided to all direct care staff for the following programs: Falls prevention and management, Skin and wound care, and Pain management, Continence care and bowel management, PASDs and restraining by physical devices.

Rationale and Summary

Pursuant to paragraph 6 of subsection 82 (7) of the FLTCA, the licensee is required to ensure that all staff who provide direct care to residents receive training in any other areas provided for in the regulations.

As per O. Reg 246/22 s. 261 (1), the licensee is required to ensure that all direct care staff receive training in the following areas:
- 1. Falls prevention and management.
- 2. Skin and wound care.
- 3. Continence care and bowel management.
- 4. Pain management, including pain recognition of specific and non-specific signs of pain.
- 5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
- 6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.

None of the home's direct care staff, including Personal Support Workers (PSWs), and registered staff, received training in the above areas. Surge Course Completion for a year period was reviewed and it was noted that Fixing Long Term Care Act (FLTCA) was the only training that was completed for the entire year.

The Executive Assistant (EA) stated that FLTCA was the only course completed on surge that year.

Sources: Surge course outline, Surge course completion training record, staff education e-mail, interview with the EA.

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