Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
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Original Public Report

Report Issue Date: October 23, 2024
Inspection Number: 2024-1401-0005
Inspection Type: Complaint Critical Incident (CI)
Licensee: Steeves & Rozema Enterprises Limited
Long Term Care Home and City: Lanark Heights Long Term Care Centre, Kitchener

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 1-3, 7-9, 2024

The following intake(s) were inspected:

- Intake: #00122364 - Anonymous complaint related to medication administration, pest control and windows in the home
- Intake: #00125266 - Falls Prevention and Management
- Intake: #00125513 - Infection Prevention and Control

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

Housekeeping, Laundry and Maintenance Services
Medication Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Falls Prevention and Management

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

Non-compliance with: O. Reg. 246/22, s. 54 (1)

Falls prevention and management

s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246/22, s. 54 (1).

The licensee has failed to comply with their strategies to reduce or mitigate falls for a resident.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that there were strategies to reduce or mitigate falls and that they were complied with.

Rationale and Summary

A resident had a history of falls and required physical assistance from staff with their activities of daily living (ADL's), including supervision with transfers.

A Personal Support Worker (PSW) observed the resident independently performing ADL's and did not assist them. The resident sustained a fall which resulted in injuries.

At the time of the inspection, observations of the resident showed that their fall prevention interventions were not fully implemented.

Failure to implement the fall prevention interventions in a resident's plan of care decreased the home's ability to reduce or mitigate falls and injury from falls for the resident.

Sources: Observations, resident care plan, kardex, progress notes, Fall Prevention and Management Program Policy (#RCM 10-02-01, dated May 18, 2022), interviews with the resident's family, Assistant Director of Care and other staff.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2); and

The licensee shall ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with any standard or protocol issued by the Director under subsection (2).

In accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, September 2023, additional requirements section 3.1 directs that the licensee must ensure surveillance actions were taken, specifically to ensure surveillance was performed on every shift, and that the surveillance information was tracked and entered into surveillance database and/or reporting tool.

Rationale and Summary

A Registered Practical Nurse (RPN) stated that resident symptom surveillance was conducted daily during interactions with residents. There was no process in the home for registered staff to document that a resident had been monitored on every shift because staff were only required to document once it was determined that a resident was symptomatic.

The IPAC Lead confirmed that there was no process in the home to document that symptom surveillance was completed for a every resident, on every shift.

When there was no process that required staff to document that they had completed resident symptom surveillance on every shift, the documentation required for the analysis related to reducing the incidence of infection and outbreaks in the home, was incomplete.

Sources: Interview with the IPAC Lead and other staff.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that any standard issued by the Director with respect to infection prevention and control (IPAC) was implemented.

A) In accordance with the IPAC Standard, revised September 2023, additional precautions must include both evidence-based practices related to potential contact precaution transmission, as well as appropriate selection and application of Personal Protective Equipment (PPE).

Specifically, the licensee has failed to ensure that staff complied with the appropriate use and application of PPE for resident #007 who required modified contact precautions.

Rationale and Summary

A resident required modified contact precautions and physical assistance from staff with their ADL's including toileting and peri-care.

Modified contact precautions required staff to don gloves when providing direct care and a gown when clothing may become soiled.

There were no gowns located in the resident's room, bathroom or at the entrance of the room and the resident stated that staff do not don gowns when assisting them.

The IPAC Lead stated that staff should be following PPE directions as per signage including donning a gown when assisting a resident with toileting and peri-care.

When staff did not follow proper PPE protocol, this put others at risk of cross-contamination.

Sources: Observations, resident kardex and care plan, interview with the resident and the IPAC Lead

B) In accordance with the IPAC Standard, revised September 2023, section 7.3 (b), the IPAC Lead shall ensure that audits are performed as required.

Specifically, the licensee had failed to ensure that the IPAC Lead had implemented audits, at least quarterly, to confirm that all staff could perform the IPAC skills required of their role.

Rationale and Summary

The IPAC Lead provided the Inspector with the home's IPAC audits from July to October 2024. There was no documentation related to auditing to ensure that all

staff can perform IPAC skills required of their role.

The IPAC Lead stated that the home's documentation was anonymous related to hand hygiene and PPE audits and that they were not aware of any audits related to specific skills of all staff, for example recreation staff versus direct care staff.

When there failed to be quarterly audits of role-specific IPAC skills, the home was unaware of the IPAC practices being implemented by all staff.

Sources: Interview with the IPAC Lead and other staff, Hand Hygiene and PPE audits