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
Dec 13, 2021	2021_944480_0006	005505-21, 007008-21, 007009-21, 007284-21, 008602-21, 010858-21, 013585-21, 014285-21, 014677-21	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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

Fox Ridge Care Community
389 West Street Brantford ON N3R 3V9

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

JENNIFER ALLEN (706480), ADELFA ROBLES (723), BARBARA GROHMANN (720920), DARIA TRZOS (561)

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): November 24, 25, 26, 29, December 1, 2, 3, 6, 2021.

The following intakes were completed in this Critical Incident inspection:
Log # 007284-21, CI: 2570-000010-21. Relating to Falls Prevention.
Log # 008602-21, CI: 2570-000013-21. Relating to Falls Prevention.
Log # 010858-21, CI: 2570-000014-21. Relating to Falls Prevention.
Log # 005505-21, CI: 2570-000007-21. Relating to Falls Prevention.
Log # 013585-21, CI: 2570-000016-21. Relating to Falls Prevention.
Log # 014285-21, CI: 2570-000018-21. Relating to Falls Prevention.
Log # 014677-21, CI: 2570-000019-21. Relating to an unexpected death.
The following follow up inspections were completed during this inspection, log # 007008-21 and log # 007009-21.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Quality Manager, Nurse Practitioner (NP), Coroner, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Housekeepers and residents.

During the course of the inspection, the inspectors toured the home and completed the IPAC checklist, observed resident and staff interactions, their home areas, and reviewed relevant clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 26. (3)	CO #001	2021_857129_0001	561
O.Reg 79/10 s. 49. (2)	CO #002	2021_857129_0001	561

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided direct care to residents related to falls.

A resident had three out of five fall incidents related to improper footwear. The resident's shoes were very loose. The family was requested to bring in a smaller pair of shoes. The resident did have other pair of shoes but did not want to wear them and the family had difficulty finding the exact same shoes in smaller size. The resident's current plan of care indicated they were at risk for falls. One of the interventions for falls prevention indicated was to ensure the resident put their shoes on before walking. The written plan of care was reviewed and revised after each fall but did not clearly identify which shoes were appropriate for the resident.

Staff confirmed that the resident's shoes were too big. The ADOC confirmed that the resident's shoes were a risk and they were removed. The ADOC also confirmed that the resident's plan of care did not give staff clear direction as to what shoes the resident was supposed to wear.

By not ensuring that clear directions were set out in the resident's plan of care, the resident continued to wear the incorrect shoe size and sustained further falls.

Sources: The resident's current written plan of care, electronic post fall assessments, progress notes and interviews with staff and the ADOC [s. 6. (1) (c)]

2. The licensee has failed to ensure that care set out in the plan of care was provided to a resident as specified in the plan related to bed alarm.

A review of the resident's current written plan of care indicated that the resident was at risk for falls. Intervention under falls prevention included the bed alarm to be engaged.

An inspector carried out multiple observations while the resident was on the bed and observed that the bed alarm was not engaged. This was confirmed by staff and the DOC.

When interventions are not provided as specified in the plan, the risk for injuries to the resident increases.

Sources: Observations, resident 's current written plan of care, electronic post fall assessments, and interviews with staff and the DOC. [s. 6. (7)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident and is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

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 infection prevention and control (IPAC) program was updated in accordance with evidence-based practices (EBPs) related to signage for hand hygiene.

During the tour of the home, Inspectors observed that there was no signage posted throughout the home to remind staff and visitors how to hand wash and how to hand rub. Ontario evidence-based hand hygiene (HH) program “Just Clean Your Hands” (JCYH) specifies how to hand wash and how to hand rub and when.
The Covid-19 Guidance Document from the Ministry of Long Term Care indicates that all homes should have signage posted throughout the home to remind everyone in the home to physically distance, wear masks and perform hand hygiene. Homes should post signage in obvious places on the premises, including at entrances and in common areas regarding how to hand wash and how to hand rub.

Interview with the Public Health Inspector from Brant County Public Health indicated that the homes should have the signage on how to hand wash posted throughout the building.

The IPAC lead stated that the home was not aware that they needed to place the signage on how to hand wash through out the home.

Sources: observations of all home areas; review of JCYH and Covid-19 Guidance from MLTC; interviews with Public Health Inspector and the DOC. [s. 229. (2) (d)]

2. The licensee has failed to ensure that staff participated in the implementation of the

infection prevention and control program specifically by not performing hand hygiene on residents, or encouraging them to do so, before and after eating.

The home’s policy on Hand Hygiene dated April 2019, stated that staff will wash residents’ hands before and after eating.

A) During lunch observation in the resident's dining room two Inspectors observed that four residents were not offered or provided hand hygiene immediately before their meals and five residents were not offered or provided hand hygiene after their meals.

Interview with the home’s IPAC Lead, confirmed that there was a gap with regards to IPAC practices in the home related to hand hygiene when residents were not offered or provided hand hygiene before and after meals.

The residents’ health were at risk of getting infection and spread of germs increased between residents when proper hand hygiene were not provided to the residents before and after meals.

Sources: Lunch observations, Hand Hygiene Policy #IX-G10.10 and IPAC Lead interview.(723)

B) Snack pass was observed on two resident home areas. It was observed that residents were not encouraged or not provided with hand hygiene by staff prior to receiving. The Quality Manager acknowledged that staff were not routinely sanitizing residents’ hands or encouraging residents to perform hand hygiene prior to consuming snacks.

The failure to perform hand hygiene on residents or encourage hand hygiene may have increased the risk of spreading infectious organisms.

Sources: Hand Hygiene Policy (# IX-G-10.10, dated April 2019), observations and interview with the Quality Manager #102. [s. 229. (4)]

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 the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and to ensure that all staff participate in the implementation of the program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's policy for oxygen therapy was complied with in relation to oxygen therapy for a resident.

LTCH Act, s. 8(1)(a) requires an organized program of nursing services for the home to meet the assessed needs of the residents.
O. Reg. 79/10, s. 30. (1) 1. Requires that for each of the required programs under s. 8 to 16 of the Act, there must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Specifically, staff did not comply with the home's policy titled "Oxygen Therapy & Services", revised April 2019.

The home's policy stated the Nurse will assess the resident's need for a treatment, obtain a physician's order for any resident requiring the treatment. The order for treatment is to include the rationale or linked diagnoses for the treatment specifics and type of equipment.

Registered staff initiated the treatment for the resident, which continued for several weeks. The physician's order was not obtained for the treatment and it was not added to the Medication Administration Record (MAR). A Registered Staff and the DOC confirmed that the orders were not obtained for the treatment and application of it was not added to the MAR for the resident.

Sources: review of the resident's plan of care; home's policy tilted "Oxygen Therapy & Services" revised April 2019; interviews with staff. [s. 8. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident sustained two falls in one shift and three falls in another shift, they were assessed using a clinically appropriate assessment instrument for each fall that was specifically designed for falls.

The following is further evidence to support the order issued on April 26, 2021, amended on May 20, 2021 during inspection 2021_857129_0001 to be complied by August 23, 2021.

A resident had two instances where they had multiple falls in a shift. On one occurrence, the resident sustained two falls, one of which resulted in an injury and significant change to their health condition. Following the resident's two falls only one post-fall assessment was completed. On the second occurrence the resident sustained three falls. Following the resident's three falls only one post-fall assessment was completed. The home required that a post fall assessment be completed by the registered staff following any fall, using the home's Post fall assessment tool.

Interview with staff stated if a resident had multiple falls in a shift, they were required to complete a post-fall assessment separately.

The ADOC confirmed it is the home's requirement that there should be post fall assessment completed after each fall.

The resident was at risk of harm relating to increased risk of having unidentified injuries or worsening injuries and a delay in the resident receiving treatment.

Sources: The resident's Assessments and Progress Notes, Falls Prevention Policy (Policy # VII-G-30.10 Current revision: July 2021) and interviews with staff. [s. 49. (2)]

Issued on this 14th day of December, 2021

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

Original report signed by the inspector.