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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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 20, 2021	2021_866585_0002 (A1)	002855-20, 002894-20, 005736-20, 011348-20, 015850-20, 016714-20, 017257-20, 024381-20, 002507-21	Critical Incident System

Licensee/Titulaire de permis

City of Hamilton
28 James Street North 4th Floor Hamilton ON L8R 2K1

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

Macassa Lodge
701 Upper Sherman Avenue Hamilton ON L8V 3M7

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

Amended by LEAH CURLE (585) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This licensee inspection report has been revised to reflect changes to findings under s. 5.

The Critical Incident System inspection, 2021_866585_0002 was completed on March 5, 9, 10, 12, 15, 16, 18, 22, 23, 24, 25, 26, 29, 30, 31, April 1, 6, 7 and 8, 2021.

A copy of the revised report is attached.

Issued on this 20th day of May, 2021 (A1)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Amended by LEAH CURLE (585) - (A1)

Amended 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): March 5, 9, 10, 12, 15, 16, 18, 22, 23, 24, 25, 26, 29, 30, 31, April 1, 6, 7 and 8, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:

Log #015850-20/ CIS M552-000034-20 was related to prevention of abuse and neglect and pain management;

Log #005736-20/ CIS M552-000019-20, log #024381-20/ CIS M552-000044-20, log #016714-20/ CIS M552-000036-20 and log #002507-21/ CIS M552-000002-21 were related to falls;

Log #011348-20/ CIS M552-000029-20 was related to personal support services; and

Log #002894-20/ CIS M552-000008-20, log #002855-20/ CIS M552-000009-20 and log #017257-20/ CIS M552-000037-20 were related to responsive behaviours and prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSWs), Housekeeping staff, Registered Practical Nurses (RPNs), Registered Nurses (RNs), the Resident Assessment Instrument (RAI) Coordinator, Nurse Managers (NMs), the Manager of Quality Improvement, Supervisor of Resident Services, Infection Prevention and Control (IPAC) Lead, Director of Care (DOC) and the Senior Administrator.

During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, reviewed records including clinical health records, policies and procedures, risk management records, Critical Incident

Report investigation files, and program evaluations.

Registered nursing student Olive Mameza Nenzeko was also present during this inspection.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

- **7 WN(s)**
- **7 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that the home was a safe environment related to their requirement to maintain infection prevention and control measures as outlined in Directive #3; specifically, that all staff complied with universal masking and wore a surgical/procedure mask for the entire duration of their shift/visit.

i) During the inspection, multiple staff working on resident home areas were observed wearing a face shield combination mask on top of a surgical mask. The Director of Care (DOC) and Infection Prevention and Control (IPAC) Lead noted there had been challenges with a combination face shield and mask product

supplied to the home as it did not fit well and slid down when worn. The home was actively working to rectify the issue and were able to resolve the matter within a few days. The IPAC Lead acknowledged the practice of wearing a face shield combination mask on top of a surgical mask was not an appropriate method of universal masking.

ii) During the inspection, a staff was beside a resident and was not wearing a surgical/procedure mask. The staff was aware of their requirement to follow universal masking procedures.

Failure to comply with universal masking requirements set out under Directive #3 increased the potential for risk of transmission of infection.

At the time of the above noted observations, the home was in a COVID-19 respiratory outbreak.

Sources: Chief Medical Officer of Health (CMOH)'s Directive #3 (issued December 7, 2020), observations of staff, interviews with the DOC, IPAC Lead and other staff.

2. The licensee has failed to ensure that the home was a safe environment related to their requirement to follow precautions and procedures with how to deal with suspected, probable or confirmed COVID-19 patients or residents as per requirements set out in Directive #5.

Directive #5 states Droplet and Contact Precautions must be used by regulated health professionals and other health care workers for all interactions with probable or confirmed COVID-19 patients or residents. Droplet and Contact Precautions include gloves, face shields or goggles, gowns, and surgical/procedure masks. Directive #3 outlines requirements for when residents require Droplet and Contact Precautions.

During the inspection, a staff entered a resident's room who was on Droplet and Contact Precaution and did not wear all required personal protective equipment. The DOC confirmed staff were expected to follow direction for Droplet and Contact Precautions for the resident as set out under Directive #5.

The lack of staff complying with requirements under Directive #5 increased the potential for risk of transmission of infection.

Sources: CMOH's Directive #3 (issued April 7, 2021), CMOH's Directive #5 (issued October 8, 2020), observation of staff and interview the DOC and other staff. [s. 5.]

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 and ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the

plan of care was documented for three residents in relation to fall interventions.

The written plan of care of three residents noted they each required specific fall interventions which was confirmed by registered nursing staff. Point of Care (POC) documentation made by PSWs did not include documentation to show the interventions for falls had been provided to the three residents. The Manager of Quality Improvement reported it was expected that staff document the provision of care for the specified fall interventions; however, the tasks were not set up in POC to allow PSWs to document that the care had been provided to the three residents.

Sources: written plans of care and POC documentation of three residents, interviews with a registered nursing staff and the Manager of Quality Improvement. [s. 6. (9) 1.]

2. The licensee has failed to ensure that a resident was reassessed and their plan of care was reviewed and revised when their care needs changed in relation to falls prevention and management.

During the inspection, specific fall interventions were observed in place for a resident. Staff reported the interventions were implemented after they experienced a fall; however, confirmed the plan of care did not include the interventions and was not revised when the resident's care needs changed.

Sources: a resident observation, a resident's clinical record, interviews with staff. [s. 6. (10) (b)]

3. The licensee has failed to ensure that a resident was reassessed and their plan of care was reviewed and revised when the care set out in the plan had not been effective in relation to managing responsive behaviours.

A resident's clinical record noted occasions when they demonstrated inappropriate behaviours. Staff and the clinical record revealed there was a known trigger for their behaviours. The written care plan listed interventions to be used and staff also reported additional interventions had been trialed to respond to the resident's needs but were known to be ineffective. The Manager of Quality improvement confirmed changes were not made to the resident's plan of care until after a subsequent incident of inappropriate behaviours.

Failure to reassess the resident increased risk of harm as they demonstrated negative behaviours on multiple occasions.

Sources: a resident's clinical record, interviews with the Manager of Quality Improvement and other staff. [s. 6. (10) (c)]

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 and ensure that the following are documented, the provision of the care set out in the plan of care; and, the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective, 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 the fall prevention procedure included in their Falls Prevention and Injury Program was complied with for three residents.

Ontario Regulation 79/10, r. 48 (1) requires that an interdisciplinary falls prevention and management program be developed and implemented in the home to reduce the incidence of falls and risk of injury.

Specifically, staff did not comply with the home's policy and procedure, "Falls Prevention and Injury Reduction Program".

The policy required registered nursing staff to initiate a SCOTT Fall Risk Screen within 24 hours of admission/readmission from hospital.

Three residents had a history of falls. For each resident, there was one occasion noted in their record when a SCOTT Fall Risk Screen was not completed after they had been readmitted from hospital. This was confirmed by registered nursing staff.

Sources: three residents clinical records, the home's policy, "Falls Prevention and Injury Reduction Program - NM 03-02-08", reviewed November 19, 2019, interview registered nursing staff. [s. 8. (1) (b)]

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 and ensure that 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 ensures that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #012 was protected from abuse by resident #011 and resident #013 was protected from abuse by resident #008.

Section 2. (1) of Ontario Regulation 79/10 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident" and verbal abuse as "any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences".

On one date in 2020, resident #012 was abused by resident #011. On two dates in 2020, resident #013 was abused by resident #008. These incidents were confirmed through interviews with staff and clinical records.

Sources: resident clinical records, interviews with the Manager of Quality Improvement and other staff. [s. 19. (1)]

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 and ensure residents are protected from abuse by anyone, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to resident #009 and resident #010 under the required pain management program, as set out in O. Reg. 79/10 s. 48 (1) 4, including assessments, interventions and the resident's responses to interventions were documented.

A Critical Incident System (CIS) report noted that two residents required action from staff on a date in 2020 in relation to pain management. Resident #009's clinical record did not include documentation of the actions taken by staff, including an assessment, interventions and response of the resident. Resident #010's clinical record did not include documentation of the intervention and the response of the resident. Registered nursing staff reported actions were taken to respond to both residents needs; however, documentation was not completed as required.

Sources: CIS report M552-000034-20 and investigative notes, two residents progress notes and assessments, interviews with registered nursing staff and other staff. [s. 30. (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 and ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee has failed to comply with the practice requirements under the Long-Term Care Home Service Accountability Agreement (LSAA), for two residents.

The Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN), under the Local Health Systems Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system.

Each resident's care and service needs shall be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the ARD (assessment reference date) of the previous assessment and will ensure that RAI-MDS tools are used correctly to produce an accurate assessment of the Health Care Service Provider's (HSP) residents and, Resident Assessment Protocols (RAPs) to be generated and reviewed and RAP assessment summaries completed for triggered RAPs and non-triggered clinical conditions within 7 days maximum of the ARD.

The home's Resident Assessment Instrument (RAI) Coordinator identified that the home used their "Pain Assessment - 2017" tool as their RAP for the non-triggered clinical condition of pain, when it was identified during a RAI-MDS assessment.

Two residents RAI-MDS assessments were reviewed. For both residents, Section J of the assessment noted they experienced pain. The residents clinical records were reviewed and both included a Pain Assessment - 2017; however, these assessments were conducted before the ARD. Completion of the RAP prior to the ARD was not consistent with the correct use of the tools. One of the two residents assessment findings were found to be inconsistent between the RAI-MDS and the RAP. The RAP for the non-triggered clinical condition of pain was not completed as required for two residents.

Sources: assessments and progress notes for two residents, interview with the RAI Coordinator. [s. 101. (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 and ensure that licensee shall comply with the conditions to which the licence is subject, to be implemented voluntarily.

WN #7: 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 all staff participated in the implementation of the infection prevention and control (IPAC) program in relation to resident hand hygiene during snacks.

The home's policy, "Hand Hygiene", stated "resident hand hygiene is to be performed before and after eating/drinking" and "staff are to encourage proper and frequent resident hand hygiene and are to assist the resident if required."

During the inspection, a snack pass was observed. Multiple residents were not offered hand hygiene before receiving their snack, which was confirmed by a staff member. The DOC confirmed it was an expectation of staff to offer residents hand hygiene before and after meals and snacks.

Not offering hand hygiene increased risk to residents as it served as a mechanism to prevent the transmission of infection.

At the time of the observation, the home was in a COVID-19 respiratory outbreak.

Sources: the home's policy, "Hand Hygiene - Policy No: IC-02-04", dated November 25, 2020, a snack observation, interviews with the DOC and other staff. [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 and ensure that all staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 20th day of May, 2021 (A1)

[redacted]

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

Original report signed by the inspector.