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

Hamilton District
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Original Public Report

Report Issue Date: January 22, 2024	
Inspection Number: 2023-1568-0005	
Inspection Type: Complaint Critical Incident	
Licensee: City of Hamilton	
Long Term Care Home and City: Macassa Lodge, Hamilton	
Lead Inspector Barbara Grohmann (720920)	**Inspector Digital Signature** Barbara Grohmann 2024.01.23 13:47:05 -05'00'
Additional Inspector(s) Patrishya Allis (000762)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 8-10, 12, 15-16, 18-19, 2024.

The following intake was inspected in this complaint inspection:

- Intake: #00102038 was related to transferring, and falls prevention and management.

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake: #00101766 (CI M552-000060-23), was related to falls prevention and management,
- Intake: #00104236 (CI M552-000064-23), was related to acute respiratory infection disease outbreak; and

- Intake: #00104399 (CI M552-000065-23), was related to COVID-19 disease outbreak.

The following intake was completed in this inspection:

- Intake: #00101955 (CI M552-000061-23), was related to falls prevention and management

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's

specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;

Minister's Directive: COVID-19 response measures for long-term care homes indicated that the licensee shall ensure that enhanced environmental cleaning and disinfection for frequently touched surfaces is performed.

Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings stated that routine practices, which included cleaning and disinfecting, are essential to prevention the transmission of organisms. It also recommended a system to ensure the efficacy of the disinfectant over time, such as reviewing expiry dates.

During an initial tour of the home, three cannisters of Oxivir Tb Wipes were observed to have expired in 2023. Two were located in resident home areas (RHA), and the third was in an administrative area.

The Infection Prevention and Control (IPAC)Lead stated that they would ensure that any expired disinfectant wipes would be removed and replaced with products that had not expired. They explained that they checked their storage area and all containers of Oxivir Tb Wipes had expiry dates of 2026.

No expired containers of Oxivir Tb Wipes were found during a follow up tour of the home.

Sources: observations; Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition (Public Health Ontario, April 2018), Minister's Directive: COVID-19 response measures for long-term care homes (August 30, 2022); interviews with the Administrator, IPAC Lead and other staff. [720920]

Date Remedy Implemented: January 15, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
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 IPAC Standard for Long-Term Care Homes section 10.1 stated that the licensee shall ensure that the hand hygiene program included access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR).

During an initial tour of the home, three bottles of ABHR that expired in 2023, one that expired in 2021 and five with unreadable expiry dates were observed.

The IPAC Lead acknowledged that expired ABHR may not have the required 70-90% alcohol content, as the expiry dates of ABHR determines the product's efficacy.

All bottles of ABHR with expired or unreadable expiry dates were removed.

Sources: observations; Infection Prevention and Control (IPAC) Standard for Long-

Term Care Homes (revised September 2023); interview with the IPAC Lead. [720920]

Date Remedy Implemented: January 15, 2024

WRITTEN NOTIFICATION: Directives by Minister

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
Binding on licensees
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to carry out every operational or policy directive that applies to the long-term care home specifically related to personal protective equipment (PPE) and masking .

Rationale and Summary
A. The COVID-19 guidance document for long-term care in Ontario specified that eye protection was required for all staff when providing care to residents with suspected or confirmed COVID-19. The home's routine and additional precautions policy required eye protection to be worn when within two metres of a resident with a suspected acute reparatory infection.

A resident tested positive for COVID-19 and was in isolation under droplet/contact precautions. Two Personal Support Workers (PSWs) provided direct care to the resident and were not wearing eye protection as part of their PPE.

The IPAC Lead stated that staff were required to wear full PPE (gown, gloves, N95 mask and eye protection) when providing direct care to a resident on isolation and under droplet/contact precautions.

B. The COVID-19 guidance document for long-term care homes in Ontario stipulated that staff, students, volunteers and support workers were required to wear masks indoors in all resident areas.

Two staff members on C1E RHA and two on C3E, were sitting near the resident television (TV) area with their masks down, exposing their nose and mouth.

The IPAC Lead explained that the home implemented mandatory masking at the start of respiratory season and universal masking was a requirement for all staff.

Failure to wear PPE and masks in accordance with Minister's Directives may have resulted in the transmission of infectious agents.

Sources: observations; a resident's clinical records, Minister's Directive: COVID-19 response measures for long-term care homes (August 30, 2022), COVID-19 guidance document for long-term care homes in Ontario (November 07, 2023), Routine Practices and Additional Precautions (IC-02-06, June 15, 2023); and interviews with the IPAC Lead and other staff. [720920]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #004 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).

A. The licensee has failed to ensure that the falls prevention and management program provided strategies to reduce or mitigate falls, including the use of equipment related to a resident's unwitnessed fall.

Rationale and Summary
A resident's care plan indicated a specific fall prevention equipment was to be used as an intervention. The resident was found on the floor by a registered practical nurse (RPN) who stated that the fall prevention equipment did not alerted them to the fall.

Contemporaneous documentation indicated that the fall prevention equipment did not signal when the resident fell and there was no task documentation to show that the it was in place at the time of the fall.

The Director of Nursing (DON) acknowledged that whether the fall prevention equipment was present and not working or not present, it did not perform as intended.

Failure to ensure that the fall prevention equipment was working and/or present, led to staff not being immediately alerted to the resident's unwitnessed fall, which resulted in an injury.

Sources: resident's clinical records; and interviews with the DON and other staff. [720920]

B. The licensee has failed to provide for strategies to reduce or mitigate falls, including the implementation of fall prevention equipment for a resident.

Rationale and Summary
A resident's family requested a specific fall prevention equipment to be used as an intervention. This was confirmed by the DON and a nurse manager.

Interviews with a PSW and a registered nurse confirmed the fall prevention equipment was not in place at the time of the resident's fall, which was also reflected in the resident's care plan.

Failure to implement the fall prevention equipment placed the resident at risk of injury post fall.

Sources: complainant e-mail, a resident's care plan, interviews with staff. [000762]

C. The licensee has failed to provide for strategies to reduce or mitigate falls, including the implementation of fall prevention equipment for a resident.

Rationale and Summary
A resident had a fall. Staff were not immediately aware as the fall prevention equipment did not signal.

Progress notes, and interviews with an RN and RPN confirmed the fall prevention equipment was not working at the time of the fall.

A PSW reported they checked the equipment was functioning at the start of their shift; however, a review of the documentation showed that staff were not

documenting falls prevention at that time. A nurse manager confirmed this should have been documented and it is therefore unknown if staff monitored the functionality of the equipment.

The non-functional fall prevention equipment may have resulted in the staff being unaware that the resident fell, which placed the resident at risk of prolonged discomfort.

Sources: CI report, resident's progress notes, interviews with staff, documentation survey report. [000762]

D. The licensee has failed to provide for strategies to reduce or mitigate falls, including the implementation of a high falls risk identifier to a resident's mobility device.

Rationale and Summary
The home's Falls Prevention and Injury Policy indicated that for any resident whose falls risk screen total score flagged them as high risk, the registered nursing staff were to apply an identifier to the resident's mobility device(s).

A resident's falls risk screen score indicated they were at high risk for falls. Observations determined that the resident's mobility device did not have the identifier which was acknowledged by two PSWs.

Failing to apply the identifier to a resident's mobility device posed a risk of potential injury to occur as it may have contributed to a lack of care measures being implemented.

Sources: resident observation, Falls Prevention and Injury Policy (RC-03-02-01,

August 4, 2023), Scott Falls Risk Screen, interviews with staff. [000762]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 2.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

The licensee has failed to provide the complainant with a follow-up response within 10 business days of receipt of the complaint, which includes the date by which the complainant can reasonably expect a resolution.

Rationale and Summary
A complaint was submitted via e-mail by a resident's family member. The Long-Term Care Home (LTCH) responded to acknowledge the complaint and indicate an investigation was underway.

Sixteen business days later, the complainant contacted the LTCH to follow-up on the investigation. The LTCH responded to the complainant's request to follow-up on the status of the investigation on the same day.

The DON confirmed the LTCH did not initiate communication with the complainant within 10 business days of receiving the complaint to provide an update or discuss the outcome of the investigation.

Failure to respond to the complainant with an update regarding the investigation within 10 business days of receiving the complaint may have resulted in a breakdown of communication with the family.

Sources: e-mail log between the complainant and LTCH, complaint logs, interview with the DON. [000762]