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 26, 2023	
Inspection Number: 2023-1223-0001	
Inspection Type: Proactive Compliance Inspection	
Licensee: Retirement Home Specialists Incorporated	
Long Term Care Home and City: Morriston Park Nursing Home, Puslinch	
Lead Inspector Romela Villaspir (653)	**Inspector Digital Signature** Romela Villaspir Digitally signed by Romela Villaspir Date: 2023.10.26 15:19:28 -04'00'
Additional Inspector(s) Nuzhat Uddin (532) Kim Byberg (729)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 12-13, 16-20, 2023, and offsite on October 24-25, 2023.

The following intake was inspected:

- Intake: #00097595 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices
Pain Management
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)
O. Reg. 246/22, s. 138 (1) (b)

The licensee failed to ensure that controlled substances were stored in a double-locked stationary cupboard in a locked medication area.

Rationale and Summary

During an observation, the inspector noted that the medication destruction bin for controlled substances was located on the floor beside the fridge and was not securely stationed on the floor.

The Office Nurse was able to remove the controlled substance destruction bin that was on the floor and acknowledged that the bin was not stationary.

On the following day, the controlled substance destruction bin was bolted and securely stationed to the cupboard by the home's maintenance supervisor.

Sources: Observations of the controlled substance bin. Interview with the Office Nurse. [729]

Date Remedy Implemented: October 20, 2023

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (2) (b)

The licensee failed to ensure that at a minimum, the policy to promote zero tolerance of abuse and neglect of residents, clearly set out what constituted neglect.

Rationale and Summary

According to O. Reg. 246/22, s. 7, for the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The home's Zero Tolerance Abuse/ Neglect policy revised in November 2013, was updated based on the LTCHA, 2007. The policy did not clearly set out what constituted neglect, and did not contain the definition of neglect as per the regulation. There were only indicators of neglect/ self-neglect outlined in the policy.

By not clearly setting out in the policy what constitutes neglect, staff members, residents, and their families may not be aware of what neglect is.

Sources: Morriston Park Nursing Home's Zero Tolerance Abuse/ Neglect policy; Interview with the Director of Care (DOC)/ Administrator. [653]

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (2) (d)

The licensee failed to ensure that at a minimum, the policy to promote zero tolerance of abuse and neglect of residents, contained an explanation of the duty under section 28 to make mandatory reports.

Rationale and Summary

According to FLTCA, 2021, s. 25 (2) (d), at a minimum, the policy to promote zero tolerance of abuse and neglect of residents, shall contain an explanation of the duty under section 28 to make mandatory reports.

According to FLTCA, 2021, s. 28 (1), A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

The home's Zero Tolerance Abuse/ Neglect policy revised in November 2013, was updated based on the LTCHA, 2007. The policy did not contain an explanation of the duty under section 28 to make mandatory reports.

By not containing an explanation of the duty under section 28 to make mandatory reports in the home's policy, staff members, and the residents' families may not be aware of this duty.

Sources: Morriston Park Nursing Home's Zero Tolerance Abuse/ Neglect policy; Interview with the DOC/ Administrator. [653]

WRITTEN NOTIFICATION: RESIDENT AND FAMILY/ CAREGIVER EXPERIENCE SURVEY

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 43 (1)

The licensee failed to ensure that, unless otherwise directed by the Minister, at least once in every year a survey was taken of the residents, to measure their experience with the home and the care, services, programs and goods provided at the home.

Rationale and Summary

During separate interviews, three residents indicated to the inspector that they were not aware of the Resident and Family/Caregiver Experience Survey, and could not recall taking such survey.

The Office Manager (OM) indicated that the Resident and Family/Caregiver Experience Survey would be communicated through the Residents' Council meetings.

The Food Services and Nutrition Manager (FNSM) who had been supporting the Residents' Council since November 2022, was not familiar with the Resident and Family/Caregiver Experience Survey.

The residents were not provided an opportunity to provide feedback on their experience with the home and the care, services, programs and goods provided at the home, through a Resident and Family/Caregiver Experience Survey.

Sources: Residents' Council meeting minutes; Interviews with the residents, the OM, and the FNSM. [653]

WRITTEN NOTIFICATION: LICENSEE OBLIGATIONS IF NO FAMILY COUNCIL

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 65 (7) (b)

The licensee failed to convene semi-annual meetings to advise residents' families and persons of importance to residents, of the right to establish a Family Council.

Rationale and Summary

The DOC/ Administrator indicated that there was no family council established in the home.

The DOC/ Administrator stated that the home mails out an information poster to the residents' family members regarding the information session on establishing a family council in the home.

The information session was only done once a year, and the last information session was held on December 12, 2022, however, no one attended.

Sources: Family Council Information Session poster for December 12, 2022; Interview with the DOC/ Administrator. [653]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING — DIRECT CARE STAFF

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (7) 6.

The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: Any other areas provided for in the regulations.

Rationale and Summary

According to O. Reg. 246/22, s. 261 (1) For the purposes of paragraph 6 of subsection 82 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management.
2. Skin and wound care.
4. Pain management, including pain recognition of specific and non-specific signs of pain.

A review of the home's surge learning report for education year 2022, indicated there were 8 Personal Support Workers (PSWs), and 4 registered staff included in the education group. According to the report, not all of these direct care staff members received the annual training on falls prevention and management, skin and wound care, and pain management, on surge learning.

The Assistant Director of Care (ADOC) indicated that the surge learning training was required to be completed upon hire and annually, thereafter.

By not receiving the additional training annually, PSWs and registered staff may not integrate best practices, strategies, and interventions as per the home's falls prevention and management, skin and wound care, and pain management programs, when providing care to the residents.

Sources: Surge learning training records year 2022; Interview with the ADOC. [653]

WRITTEN NOTIFICATION: CONTINENCE CARE AND BOWEL MANAGEMENT

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (c)

The licensee failed to ensure that a resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

Rationale and Summary

A resident required assistance and support from staff, to manage and maintain continence.

The resident indicated there had been occasions wherein they had to wait for a long period of time to receive the support they required to maintain their continence. The resident further indicated they had

episodes of incontinence a couple of times in the past due to having to wait for a long period of time.

By not receiving the assistance from staff, the resident was unable to manage and maintain their continence.

Sources: Resident's clinical health records; Interviews with the resident, PSW, and the DOC/ Administrator. [653]

WRITTEN NOTIFICATION: EVALUATION

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 106 (b)

The licensee failed to ensure that at least once every calendar year the home's zero tolerance of abuse and neglect policy was evaluated to determine the effectiveness of the licensee's policy, and the changes/ improvements required to prevent further occurrences.

Rationale and Summary

The home's Zero Tolerance Abuse/ Neglect policy revised in November 2013, referred to the LTCHA, 2007 and O. Reg 79/10. The home's policy had not been updated to reflect the new FLTCA 2021, or O. Reg. 246/22.

The DOC/ Administrator stated that they reviewed the home's Zero Tolerance of Abuse/Neglect policy; however, they did not complete an evaluation, analyze incidents, outcomes, or review trends of the home's zero tolerance of abuse and neglect program.

There was ongoing risk to residents when the home failed to evaluate the zero tolerance of abuse/neglect program and implement changes that may prevent further occurrences of abuse towards residents.

Sources: Morriston Park Nursing Home's Zero Tolerance Abuse/ Neglect policy, document titled "Policy and Procedure Manuals" dated: January 2023. Interview with the DOC/Administrator. [729]

WRITTEN NOTIFICATION: CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 9.

The licensee failed to ensure that the home's continuous quality improvement committee was composed of at least one member of the home's Residents' Council.

Rationale and Summary

The DOC/ Administrator indicated that the home had a continuous quality improvement committee, and the ADOC was the designated lead of the home's continuous quality improvement initiative.

The DOC/ Administrator acknowledged that as of current, the committee did not include at least one member of the home's Residents' Council.

By not including at least one member of the home's Residents' Council in the committee, there was a lack of resident representation, and suggestions for continuous quality improvement opportunities from the perspective of residents, were not taken into consideration.

Sources: Morriston Park Quality Improvement Plan (QIP) April 3, 2023; Interview with the DOC/ Administrator. [653]

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) 3.

The licensee failed to ensure that the continuous quality improvement initiative report contained a written description of the process used to identify the home's priority areas for quality improvement for the next fiscal year and how the home's priority areas for quality improvement for the next fiscal year were based on the recommendations of the home's continuous quality improvement committee.

Rationale and Summary

The home's continuous quality improvement initiative report 2022/2023, and the quality improvement plan dated April 3, 2023, did not contain a written description of the process used to identify the home's priority areas for quality improvement for the next fiscal year, and how the home's priority areas for

quality improvement for the next fiscal year were based on the recommendations of the home's continuous quality improvement committee.

By not documenting a written description of the process used to identify the home's priority areas in the home's continuous quality improvement initiative report, residents and their families were not apprised of the home's processes.

Sources: Morriston Park Quality Improvement Plan (QIP) April 3, 2023, continuous quality improvement initiative report 2022/2023; Interview with the DOC/ Administrator. [653]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING — DIRECT CARE STAFF

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 1.

The licensee failed to ensure that training on falls prevention and management was provided to a Registered Nurse (RN) who provided direct care to residents.

Rationale and Summary

The ADOC indicated that the falls prevention and management training was provided to all staff through surge learning upon hire and annually, thereafter.

A RN was hired at the Morriston Park Nursing Home in 2023, and had been working full-time hours. The RN confirmed to the inspector that they did not receive training on the home's falls prevention and management program through surge learning upon hire.

Sources: Staff training records; Interviews with the ADOC, Office Nurse, and the RN. [653]

WRITTEN NOTIFICATION: ADDITIONAL TRAINING — DIRECT CARE STAFF

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 261 (1) 2.

The licensee failed to ensure that training on skin and wound care was provided to a RN who provided direct care to residents.

Rationale and Summary

The ADOC indicated that the skin and wound care training was provided to all staff through surge learning upon hire and annually, thereafter.

A RN was hired at the Morriston Park Nursing Home in 2023, and had been working full-time hours. The RN confirmed to the inspector that they did not receive training on the home's skin and wound care program through surge learning upon hire.

Sources: Staff training records; Interviews with the ADOC, Office Nurse, and the RN. [653]

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) 4.

The licensee failed to ensure that training on pain management, including pain recognition of specific and non-specific signs of pain, was provided to a RN who provided direct care to residents.

Rationale and Summary

The ADOC indicated that the pain management training was provided to all staff through surge learning upon hire and annually, thereafter.

A RN was hired at the Morriston Park Nursing Home in 2023, and had been working full-time hours. The RN confirmed to the inspector that they did not receive training on the home's pain management program through surge learning upon hire.

By not receiving the additional training upon hire, the RN may not integrate best practices, strategies, and interventions as per the home's falls prevention and management, skin and wound care, and pain management programs, when providing care to the residents.

Sources: Staff training records; Interviews with the ADOC, Office Nurse, and the RN. [653]

WRITTEN NOTIFICATION: WEBSITE

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 271 (1) (e)

The licensee failed to ensure that the home had a website that was open to the public and included at a minimum, the current report required under subsection 168 (1).

Rationale and Summary

According to O. Reg. 246/22, s. 168 (1) Every licensee of a long-term care home shall prepare a report on the continuous quality improvement initiative for the home for each fiscal year no later than three months after the end of the fiscal year and, subject to section 271, shall publish a copy of each report on its website.

The DOC/ Administrator acknowledged that the continuous quality improvement initiative report was not posted on the home's website, alternatively, it was e-mailed out to the family members, and posted on the bulletin board at the home for the residents.

Sources: Morriston Park website, Morriston Park Quality Improvement Plan (QIP) April 3, 2023, continuous quality improvement initiative report 2022/2023; Interview with the DOC/ Administrator. [653]