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 East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: January 8, 2024	
Original Report Issue Date: November 20, 2023	
Inspection Number: 2023-1227-0001 (A1)	
Inspection Type: Complaint Critical Incident	
Licensee: Medlaw Corporation Limited	
Long Term Care Home and City: Pinecrest Nursing Home (Bobcaygeon), Bobcaygeon	
Amended By Sharon Connell (741721)	**Inspector who Amended Digital Signature** Sharon Connell Digitally signed by Sharon Connell Date: 2024.01.10 10:15:19 -05'00'

AMENDED INSPECTION SUMMARY

This report has been amended to reflect a compliance due date extension for Non-compliance #020, Compliance Order #001, from original date of January 31, 2024, to an amended date of February 16, 2024.

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Lead Inspector Sharon Connell (741721)	**Additional Inspector(s)** Sheri Williams (741748)
Amended By Sharon Connell (741721)	**Inspector who Amended Digital Signature** Sharon Connell Digitally signed by Sharon Connell Date: 2024.01.10 10:14:36 -05'00'

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 25 - 29, and October 3 - 6, 2023.

The following intake(s) were inspected:
· Intake: #00007295 - related to medication.
· Intake: #00013372 - related to resident-to-resident abuse.
· Intake: #00015453 - related to falls.
· Intake: #00097451 - complaint related to resident care.

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Pain Management
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 131 (2)

The Licensee failed to ensure that a resident's medication was administered according to prescriber directions.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director due to a residents medication incident.

On two consecutive days, a resident required transfer to hospital for treatment related to an unstable medical condition and returned with new prescriber orders.

A review of the clinical health record indicated that on two separate occasions registered staff independently withheld a specific medication for the resident without consulting the prescriber for direction.

In an interview with the Administrator, they acknowledged that registered staff should have called the doctor to alter medication times and did not administer medications according to prescriber directions for the resident.

Failing to ensure a resident received their medication in accordance with prescriber directions, placed them at risk of harm related to their unstable medical condition.

Sources: High Alert Medication Policy, clinical record, interviews with Administrator. [741748]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)

The licensee failed to take appropriate action when a head-to-toe physical assessment was not completed for a cognitively impaired resident, after a report of alleged abuse.

Rationale and Summary:

A critical incident report (CIR) was submitted to the Director, that alleged abuse of a resident when they were found in bed partially clothed with another resident who was completely undressed. The resident who was allegedly abused was described as cognitively impaired and unable to provide consent.

The risk management report for resident #006 indicated documentation of no injuries after the alleged abuse, however there was no description of a head-to-toe assessment found in either the progress notes or the risk management report.

A registered staff acknowledged that a head-to-toe assessment was not completed for either resident after the alleged abuse, and they had documented that there were no injuries after taking the word of the personal support worker (PSW) who had notified them about the incident.

The Director of Care (DOC) confirmed that registered staff were expected to complete a head-to-toe assessment, to look for injuries after an alleged abuse, and record their assessment under Risk Management in the electronic chart. They confirmed that resident #006 was allegedly abused and should have had a head-to-toe assessment done.

The Abuse Neglect Policy 2023, directs registered staff to conduct a head-to-toe physical assessment on the alleged victim and document findings if physical abuse is alleged (in Risk Management).

By failing to take appropriate action, such as a head-to-toe physical assessment, in response to an alleged sexual abuse for resident #006, the licensee increased the risk of complications from undetected injuries.

Sources: CIR, clinical records, Abuse Neglect policy, staff interviews (RPN and DOC). [741721]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee failed to notify the Director of a complaint related to improper or incompetent treatment or care, that resulted in harm or a risk of harm to a resident.

Rationale and Summary:

A complaint from a substitute decision maker (SDM) was received by the home identifying concerns related to improper care of a resident. A critical incident report (CIR) was not submitted to the Director related to this complaint.

The Director of Care (DOC) noted in the resident's family communication progress note, that the family were once again upset about the care and were concerned about the condition they had found their family member in. The SDM expressed concerns about the resident's state of undress, assistive devices not applied, and their unmade bed.

The DOC confirmed that there had been a number of ongoing issues which they felt had been addressed and they hadn't received any further complaints from the SDM. They confirmed that they didn't report complaints to the Ministry if they were resolved right then, and the complainant was happy with that.

A Registered staff documented a phone conversation in the progress notes, that the Power of Attorney (POA) had expressed anger about staff from previous shifts and the care that had not been provided. The RN acknowledged that they were sorry they were upset, and the POA shared that they were beyond upset, they were very angry.

The home's, 'Concerns & Complaints Reporting' policy directed staff to report, document, investigate and respond to all complaints and concerns related to the care of a resident or the operation of the home. The policy then refers the reader to the Prevention of Abuse and Neglect policy which directs staff to immediately report to the Director any suspicion of improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.

Failure of the licensee to notify the Director of a complaint related to improper or incompetent treatment or care, increased the risk of harm or risk of harm from neglect of care for the resident.

Sources: Progress notes, Concerns & Reporting policy, DOC interview. [741721]

WRITTEN NOTIFICATION: PROVISIONS IN PLAN OF CARE

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 35 (2) 6.

The licensee failed to ensure the plan of care for three residents provided for everything required under subsection (3).

Rationale and Summary:

During observations in the home related to a complaint and critical incidents, three residents were found to have a physical device used as a restraint.

The home's restraint policy directs that the plan of care identifies potential risk to the resident or another person if the resident was not restrained, alternatives considered, method of restraining, physician order, consent, how often and how long the restraint can be used and release time for toileting and repositioning. The plan should also include: the type of device to be used and in what circumstances, how often and for how long the restraint can be used, schedule for monitoring use including frequency, by whom and how, release time for repositioning and toileting, and interventions with clear instructions to guide the provision of care.

A review of the clinical health records for the two of the residents did not include any of the provisions required for in the plan of care related to restraints and indicated only to follow the policy and procedure. One of the residents had no plan of care provisions related to restraint use.

Interviews with two registered staff and the Director of Care (DOC) confirmed that they did not follow the requirements of the home's restraint policy for the three residents.

Failing to comply with the provisions for plan of care for safe use of a restraint for the three residents posed a risk of significant harm and safety.

Sources: Restraint policy, clinical records, interviews with two registered staff and DOC. [741748]

WRITTEN NOTIFICATION: ORAL CARE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 38 (2)

The licensee failed to provide a resident with assistance to insert dentures prior to meals and at any other time as requested by the resident or required by the resident's plan of care.

Rationale and Summary:

During observations in the home, a resident was found seated in their room after returning from breakfast, and their dentures were found dry and sitting in a denture cup on the bedside table.

A PSW who had attempted to assist the resident with breakfast, responded that they didn't wear them when asked if they had dentures.

The care plan for the resident noted that they were unable to express their needs and required total care. The plan contained no information about the resident's dentures, despite being high risk for their nutritional status related to cognitive impairment and poor dentition.

By failing to provide the resident with assistance to insert dentures prior to meals and at any other time as requested by the resident or required by the resident's plan of care, the licensee increased the risk of nutritional deficits.

Sources: Observations, clinical records, staff interview (PSW #122). [741721]

WRITTEN NOTIFICATION: DRESS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 44

The licensee failed to ensure that multiple residents were assisted with dressing as required, and were dressed appropriately, suitable to the time of day and in keeping with the resident's preferences, in their own clean clothing and in appropriate clean footwear.

Rationale and Summary:

An anonymous complaint was received from a visitor describing that they had seen residents in the common areas not dressed from the waist down and when the sheet draped over their lap had fallen off, they expressing there was no dignity for the resident. The visitor described a specific incident when a resident had kicked their sheet off and there were no staff there to put the sheet back on.

Over the course of two meal observations, one lunch and one breakfast, three residents were observed to be inappropriately dressed while sitting at their dining table waiting for meal service. Two residents were observed wearing blue hospital gowns, one had a fleece top, and all had a white sheet placed over their laps.

A Personal Support Worker (PSW) explained that one of the residents was wearing a hospital gown at the lunch dining table because they were going for a bath immediately after lunch and it was normal for residents to remain undressed waiting for their bath, which could be later in the day.

The Physiotherapy Assistant (PTA) confirmed that one of the residents was normally dressed when taken to the dining room but for that meal they were wearing a hospital gown as they were waiting to have their bath and staff wanted to avoid additional agitation caused by changing them more than once.

The care plan for all three residents noted an impaired ability to dress, with one resident requiring extensive assistance, and the other residents requiring total care for dressing.

The Director of Care (DOC) confirmed that sometimes when residents were having a bath after breakfast they would come to breakfast in pajamas and a housecoat, if they were okay with that, but the protocol was to have all residents dressed before coming to lunch.

Failure of the licensee to dress the three resident's appropriately, suitable to the time of day, was disrespectful to their dignity.

Sources: Observations, clinical records, interviews (PSW, PTA, visitor, DOC). [741721]

WRITTEN NOTIFICATION: SKIN AND WOUND

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (1) 4.

The licensee failed to ensure that a resident, who had altered skin integrity, received skin treatments and interventions.

Rationale and Summary:

A critical incident report (CIR) was submitted to the Director for a resident related to a fall incident that resulted in a change in medical condition.

Physician orders required a specific resident to receive various medical treatments at specific intervals. A review of the treatment administration record and progress notes confirmed that the prescribed treatments were not completed as ordered for the specified dates.

A Registered Staff and the Director of Care (DOC) confirmed treatments should occur as ordered and acknowledged they were not done.

Failing to ensure treatments for a resident were completed as ordered, put them at moderate risk of medical complications, infection, and pain.

Sources: CIR, clinical health record, staff interviews (Registered staff and DOC). [741748]

WRITTEN NOTIFICATION: SKIN AND WOUND

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

The Licensee failed to ensure that a resident received a skin assessment upon return from hospital.

Rationale and Summary:

A critical incident report (CIR) related to the fall of a resident was submitted to the Director.

The home's Skin and Wound policy directs that residents are to have a head-to-toe skin assessment completed after a return from hospital.

The clinical health care record for resident #001 shows they did not receive a head-to-toe assessment upon return from a transfer.

Three Registered Staff and the Director of Care (DOC) confirmed that a head-to-toe assessment for resident #001 should have been completed on their return from hospital.

Failure to complete a head-to-toe assessment for the resident placed them at moderate risk of harm from infection, and skin breakdown.

Sources: CIR, clinical records, Skin and Wound policy, staff interviews (three Registered Staff and DOC). [741748]

WRITTEN NOTIFICATION: SKIN AND WOUND

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA 2007, s. 50 (2) (b) (i)

The licensee has failed to ensure that a resident, who had altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument, specifically designed for skin and wound assessment.

Rationale and Summary:

A Critical Incident Report (CIR) that was submitted to the Director regarding a medication incident contained details that the resident had a history of altered skin integrity on admission.

The home's Skin and Wound Policy directed registered staff to complete a skin and wound assessment in the electronic health care record for residents with altered skin integrity.

The resident's clinical record showed no documentation of an assessment of their altered skin integrity, using a clinically appropriate assessment instrument, designed for skin and wound assessments.

Interviews with the Administrator acknowledged that the expectation of the home is that a skin and wound assessment should have been completed for the resident with altered skin integrity.

Failure to ensure that the resident received an assessment of their altered skin integrity placed them at moderate risk of worsening skin breakdown, infection, and pain.

Sources: CIR, Skin and Wound policy, clinical health record, interview with Administrator. [741748]

WRITTEN NOTIFICATION: SKIN AND WOUND

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iii)

On April 11, 2022, O. Reg. 246/22 and the FLTCA came into force, for which the requirement was under s. 55 (2) (b) (iii) for the home to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented. This legislation was revoked on April 11, 2023, and replaced with O. Reg, 55 (2) (e). Non-compliance occurred on December 6, 2022, which falls under s. 55 (2) (b) (iii).

The licensee failed to ensure that a resident with skin alteration, was assessed by a registered dietician, and any changes made to the plan of care relating to nutrition and hydration were implemented.

Rationale and Summary:

A critical incident report (CIR) was submitted to the Director for a resident who required transfer to hospital for an incident that caused an injury resulting in significant change in condition.

The home's skin and wound policy directs that an assessment by a registered dietician is to be completed for a skin alteration.

A review of the resident's health record indicated that medical complications were observed post injury when the dietician referral was not completed.

Three registered staff and the Director of Care (DOC) acknowledged that a dietary assessment should have been completed for the resident.

Failure to complete an assessment referral to the registered dietician posed a moderate risk of medical complications related to nutrition and weight loss.

Sources: CIR, Skin and Wound policy , clinical records, staff interviews (three registered staff and DOC). [741748]

WRITTEN NOTIFICATION: SKIN AND WOUND

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee failed to ensure that a resident who had altered skin integrity, was assessed at least weekly by a member of the registered nursing staff.

Rationale and Summary:

A critical incident report (CIR) was submitted to the Director for a resident who required treatment for an injury sustained from a fall.

A review of the treatment administration record (TAR) and progress notes indicated that two consecutive weekly wound assessments were missed.

Three registered staff and the Director of Care (DOC) acknowledged that wound assessments should have been completed weekly.

Failing to ensure that a resident received a weekly skin assessment put them at moderate risk of worsening skin alteration, infection, and pain.

Sources: CIR, clinical records, interviews with registered staff and DOC. [741748]

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 1.

The licensee failed to ensure their pain management program included assessment methods for residents with cognitive impairment.

Rationale and Summary:

A critical incident report (CIR) was submitted to the Director for a resident who required treatment for an injury sustained from a fall.

Review of the resident's clinical health record identified that the resident did not have any orders for medication for pain management post fall injury.

The resident was given pain medication using the home's medical directive orders which provide analgesic dosage and timing ranges to be used for elevated temperatures and minor aches and pains before consulting the physician.

The home's pain management policy directs staff to assess residents with cognitive impairment with the PAINAD Scale when administering pain medications.

Progress notes and the medication administration records (MAR) for the resident indicated that they received an analgesic as per the medical directive on five different days over the course of a week. The resident's pain was documented as 0-5 using a numerical pain scale indicating that the resident was asked to rate their pain.

During review of progress notes pain assessment was not completed, the PAINAD scale was not observed for the resident who had significant cognitive impairment.

Three registered staff and the Director of Care (DOC) acknowledged that the cognitively impaired resident should have been assessed using the PAINAD Scale prior to administering the analgesic medication for pain.

Failure to assess the residents pain using an assessment method for residents with a cognitive impairment, posed a moderate risk that their pain was not effectively communicated, evaluated, and managed.

Sources: CIR, Pain Management policy, clinical records, interviews with registered staff and DOC. [741748]

WRITTEN NOTIFICATION: HOUSEKEEPING

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)

The licensee has failed to ensure that procedures were developed and implemented for cleaning and disinfection in accordance with manufacturer's specifications.

Rationale and Summary:
Housekeeping procedures were observed during a mandatory infection prevention and control (IPAC) program review due to a parainfluenza outbreak. Tracking of concentration testing from wall dispensers for the home's disinfectant was observed to be posted on the wall of the housekeeping closet and had two-to-five-day gaps in documentation.

A housekeeper confirmed that they used the outbreak strength disinfectant solution during outbreaks and the Environmental Services Manager (ESM) was responsible for performing concentration checks.

The ESM demonstrated two concentration tests, one for the regular and the other for the outbreak strength as labelled on the wall dispenser. The regular strength disinfectant solution failed the strip test, and the outbreak strength solution passed. The failed test strip did not turn colour to a light blue as required for a pass. They confirmed that concentration testing was usually done two times per week, and they would need to ask the disinfectant manufacturer's representative what the recommended frequency of testing was.

The manufacturer's representative responded via email to the ESM confirming that best practice was to have the diluted disinfectant tested at the start of each shift change, so that incoming staff wouldn't have to question what they were using and would have verified it themselves.

The homes policy entitled 'HK - General Cleaning Practices', directed staff to follow the manufacturer's instructions for proper dilution and contact time for cleaning and disinfecting solutions but failed to provide any directions for the product that was currently in use.

The ESM acknowledged that they had talked to the manufacturer's representative who recommended testing the disinfectant concentration before every shift or daily, so they had started to test daily.

Failing to ensure that procedures were developed and implemented for cleaning and disinfecting, specifically related to concentration testing, placed the home at an increased risk for transmission of infection.

Sources: Observation of concentration testing, HK - General Cleaning Practices policy, manufacturer's email, staff interviews (Housekeeper, ESM). [741721]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 1.

The licensee failed to ensure that an infection prevention and control lead worked regularly in that position, on site, for a minimum of 17.5 hours per week.

Rationale and Summary:

The Infection Prevention and Control (IPAC) lead confirmed that they do not always work 17.5 hours per week as per legislation for homes under 69 beds. They confirmed that they were scheduled for two IPAC 7.5 hour shifts this week and next week only one IPAC shift as they had been reassigned to cover a registered staff shortage.

The Director of Care (DOC) explained that during an outbreak they try to schedule the IPAC Lead to work extra so they have time to be on the floor to see what is happening and keep up to date on surveillance and tracking but acknowledged that in reality this was not always possible, and resident care had to come first if they were short staffed.

Review of the IPAC Lead's work schedule for September 2023 confirmed that three shifts had been cancelled and not rescheduled and the maximum number of hours worked in a week was 15. During the outbreak, in the final week of September, the lead worked only 9.5 hours out of the required 17.5.

The July 2023 evaluation of the IPAC program noted that the IPAC Lead would be scheduled for 2-3 IPAC shifts per week, which does not meet the required minimum of 17.5 hours for homes with a capacity of 69 or fewer beds.

By failing to ensure that the IPAC Lead worked regularly in that position, on site, for 17.5 hours a week, the licensee increased the risk for spread of disease related to reduced IPAC surveillance, education and monitoring activities in the home.

Sources: September IPAC work schedule, 2023 IPAC program evaluation, staff interviews (IPAC Lead, DOC). [741721]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to implement a standard issued by the Director with respect to infection prevention and control.

1. The licensee failed to ensure that routine practices including hand hygiene after resident and resident environment contact was not performed by staff as was required by Additional Requirement 9.1 (b) under the Infection Prevention and Control (IPAC) Standard.

Rationale and Summary:

During a resident transfer a personal support worker (PSW) was observed entering into the resident's room and pushing their wheelchair to the dining room missing two opportunities for hand hygiene. In the main dining room hand hygiene was observed infrequently when positioning residents and setting them up for their meal.

A housekeeper was observed to be putting on gloves to enter a resident's room with no hand hygiene after finishing cleaning in a different room. The housekeeper acknowledged that they were aware of the four moments in hand hygiene, confirming they had missed an opportunity to clean their hands.

A registered staff was observed to be attempting to perform hand hygiene after glove removal when their thumbs were still in the contaminated gown. Later after performing further resident care tasks, they proceeded to remove their personal protective equipment (PPE) missing hand hygiene prior to goggle and mask removal.

The IPAC Lead acknowledged that hand hygiene could not be performed properly by the registered staff when their thumbs remained in the loops of the contaminated disposable isolation gown.

The home's policy entitled 'IPAC: Routine practice – PPE, directed staff to immediately remove gloves after completion of the task that requires gloves, before touching clean environmental surfaces, clean hands immediately after removing

gloves, and not to wear the same pair of gloves for the care of more than one resident. The policy also directs staff to perform hand hygiene before and after each resident contact and after contact with resident belongings and equipment.

The home's policy entitled: 'HK General Cleaning Practices' directed housekeeping staff to clean hands when leaving the unit and the room.

Failure to perform the four moments in hand hygiene, increased the risk of ongoing spread of disease in an outbreak setting.

Sources: Multi-day observations, HK General Cleaning Practices policy, IPAC: Routine practice – PPE policy, staff interviews (Housekeeper, IPAC Lead). [741721]

2. The licensee failed to clean isolation rooms twice daily while the home was in outbreak, as was required by Additional Requirement 9.1 (g) under the IPAC Standard.

Rationale and Summary:

Isolation room cleaning checklists for two separate resident rooms were missing several entries for the second clean. One cleaning checklist was started two days late for a resident room in isolation and was missing the second p.m. clean for five consecutive days during the outbreak. Another isolated resident room was missing the second p.m. clean for two consecutive days during the outbreak.

A memo posted in the housekeeping closet dated March 2023, instructed housekeepers to perform twice daily cleaning in isolation rooms during outbreaks.

A Housekeeper acknowledged awareness of the expected outbreak cleaning protocols, pointing to the outbreak cleaning memo that was posted on the disinfectant wall dispenser in the housekeeping closet.

The Administrator confirmed that isolation rooms required twice daily cleaning of frequently touched surfaces, preferable once in the morning and then once near the end of the shift. They acknowledged that the missing second cleans for the two isolation rooms should have been done.

Failure to perform twice daily isolation room cleaning during outbreak, increased the risk for spread of disease.

Sources: Isolation room cleaning checklists, March 2023 Housekeeper Memo re:

3. The licensee has failed to implement a standard issued by the Director with respect to infection prevention and control.

The licensee failed to ensure that proper use of personal protective equipment (PPE), including appropriate selection, application, removal, and disposal was performed as required by Additional Requirement 9.1 (f) under the IPAC Standard.

Rationale and Summary:

A change in the use of PPE became evident when staff began to add eye protection during resident care activities in the dining room.

A Personal Support Worker (PSW) was observed putting on PPE to enter a semi-private isolation room, and after delivering the first snack to the isolated resident, they returned to the snack cart for a second snack and without changing PPE proceeded back in to assist the non-isolated roommate.

Upon two different exits from the same isolation room a registered staff was observed wearing contaminated PPE when using the medication cart and incorrectly performing or missing hand hygiene opportunities during the PPE donning or removal steps.

A PSW confirmed that they did not change their PPE when delivering snacks between roommates of an isolation room.

The IPAC Lead acknowledged that the PSW should have changed their PPE between residents in the isolation room, and the registered staff should have removed their contaminated PPE before returning to the medication cart.

The 'IPAC - Routine Practice - PPE' policy directs staff not to wear the same gown when going from resident to resident and to remove their gown immediately after the task for which it had been used.

Failure to ensure the proper use of PPE, including appropriate selection, application, removal, and disposal, increased the risk of ongoing spread of disease in an outbreak setting.

Sources: Staff observations, 'IPAC - Routine Practice - PPE' policy, interviews (PSW, IPAC Lead). [741721]

4. The licensee failed to ensure that best practices related to the handling and placement of contaminated resident care equipment were followed as required by Additional Requirement 9.1 (e) under the IPAC Standard.

Rationale and Summary:

A registered staff was observed to have removed contaminated equipment from an isolated residents room, placing it on the medication cart while removing their PPE and preparing to clean the equipment.

Mop heads and a plastic bag of microfibre cloths were observed to be sitting next to goggles on a clean drying table outside the housekeepers closet.

The IPAC Lead acknowledged that the registered staff should not have placed contaminated equipment on the surface of the medication cart.

The Administrator and IPAC Lead in two separate interviews confirmed that it was not acceptable for mop heads to be placed beside goggles on a clean drying table.

The home's policy entitled, 'IPAC Routine Practice PPE' directed staff to bring dedicated equipment into the room to be used during the isolation period. The policy also stated to use contact precautions when handling environmental surfaces or care items from residents who are infected or suspected to be.

Failure to perform best practices related to handling and cleaning of contaminated resident care equipment as per contact precautions, increased the risk for spread of disease.

Sources: Observations, 'IPAC Routine Practice PPE' policy, staff interviews (IPAC Lead, DOC). [741721]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

The licensee failed to ensure that resident symptoms of illness were monitored on every shift in accordance with evidence-based practice.

Rationale and Summary:

The home's Infection Prevention and Control (IPAC) program was reviewed due to the facility-wide parainfluenza outbreak.

The IPAC Lead indicated that staff were expected to assess residents with symptoms of illness on each shift and complete charting in the progress notes.

Review of progress notes for one of the resident cases showed that there were missing entries for one evening and five night shifts and several other infection notes indicating that the resident remained isolated but contained no details of symptom monitoring.

During the resident's illness period there was an evening progress note related to cough and nasal congestion. The only documentation found on the next three shifts was a report sheet that included two temperature readings, and progress notes that indicated they remained in isolation with no concerns.

One week into the illness, a progress note for the same resident recorded multiple symptoms including inability to sit upright, lethargy, incoherent speech, difficulty swallowing, productive cough, and they were started on antibiotics.

Failing to ensure that the resident was monitored every shift for symptoms indicating infection, increased the risk of medical complications related to potential delay in treatment.

Sources: Clinical records, outbreak line list, shift report sheets, staff interview (IPAC Lead). [741721]

WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (2)

The licensee failed to notify a resident's substitute decision maker (SDM) of the results of an abuse investigation required under subsection 27 (1) of the Act, immediately upon the completion of the investigation.

Rationale and Summary:

The Director of Care (DOC) provided their abuse investigation package related to an alleged abuse critical incident report (CIR) submitted to the Director, none of the photocopied documents contained in the package verified that the SDM was provided with the results of the investigation.

A progress note written by the DOC quoted an email sent to the SDM that explained the actions that the home had taken to prevent further abuse, and invited the SDM to call if they had any questions, but contained no information about the results of the investigation.

The home's Abuse Neglect policy stated that the DOC, or Administrator was responsible for contacting the resident's SDM with results of an investigation, immediately upon completion of the investigation.

Failure of the licensee to report the results of an alleged abuse investigation to the resident's SDM, could have impacted future care decisions made without this information.

Sources: CIR, family communication progress notes, investigation package, Abuse Neglect policy. [741721]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3.

The licensee failed to provide a response to the Substitute Decision Maker (SDM) within 10 days of a complaint that specifically included: Ministry and patient ombudsman contact information, an explanation of what was done to resolve the complaint, and confirmation of forwarding the complaint to the Director.

Rationale and Summary:

A family communication progress note documented that a family were once again upset about the care of their family member and concerned about the condition they had found them during a visit. The note included a copy of a memo sent to staff to highlight specific care expectations for the resident.

Progress notes showed no documentation of a response provided to the SDM within 10 days of the complaint about improper or incompetent care of the resident that resulted in harm or risk of harm.

The Concerns & Complaints Reporting policy directed staff to report, document, investigate and respond to all complaints and concerns related to the care of a resident and referred the reader to the Prevention of Abuse and Neglect policy which directed staff to immediately report to the Director any suspicion of improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.

The DOC acknowledged that they failed to document that the SDM was happy with the discussed plan of action to resolve the complaint. They also confirmed that they did not write a letter in response to the concerns, they spoke directly to the SDM on the phone explaining what they would be doing. The DOC confirmed that the Ministry Action Line and Ombudsman contact numbers were not provided to the SDM, as they were only provided in a letter format if a complaint was reported to the Ministry.

By failing to provide a response to the resident's SDM (complainant) that included specifically: Ministry and patient ombudsman contact information, an explanation of what the licensee had done to resolve the complaint, or reasons why it was believed to be unfounded, and confirmation of forwarding the complaint to the

Director, the licensee increased the risk of harm by withholding information that could impact future care decisions.

Sources: Progress notes, Concerns & Complaints Reporting policy, DOC interview. [741721]

WRITTEN NOTIFICATION: MEDICATION INCIDENTS AND ADVERSE DRUG REACTIONS

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (3) (a)

The licensee failed to ensure a quarterly review was completed of all medication incidents.

Rationale and Summary:

A critical incident report (CIR) was submitted to the Director for a medication incident that occurred as a result of a specific medical condition, requiring transfer of the resident for treatment.

The Administrator indicated that the home did complete a quarterly review of medication incidents, but was unable to provide a written record of the evaluation since April 2023.

Failing to compete quarterly evaluations of medication incidents that occurred as a result of a specific medical condition posed a risk for further incidents occurring and a risk to the health and wellbeing of the resident.

Sources: CIR, quarterly and annual medication evaluations, Administrator interview. [741748]

(A1) The following non-compliance(s) has been amended: NC #020

COMPLIANCE ORDER CO #001 POLICY TO MINIMIZE RESTRAINING OF RESIDENTS

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 33 (1) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Ensure resident's #001, #006 and #010, and any other resident in the home who are restrained by a physical device are used in compliance with the home's Restraint Policy including but not limited to assessment, reassessments, consents, physician order, plan of care, release and position
documentation, and monitoring.

2. Management of the home is to complete an audit to evaluate all residents who have a personal assistance service device (PASD) or a physical restraint regardless of their physical and cognitive ability. The audit should evaluate the resident's ability to release themselves on request and classify if the device used meets the definition of a restraint or PASD. Keep a documented record of the audit and make available to Inspectors immediately upon request.

3. Management of the home will audit all restraints and PASD's in use daily for two weeks then three times a week for six weeks. The audit should include the consent, method of restraining, that the resident is monitored while restrained, that the resident is released and repositioned, and that the resident is restrained only for as long as necessary. When failings are identified in the audit, corrective action needs

to be taken, and a record of this is to be kept. Keep a documented record and make available to the inspectors immediately upon request.

Grounds:

1. The licensee failed to comply with the home's Restraints policy for resident #001.

Specifically, to ensure completion of the initial assessment form, written consent, plan of care and monitoring was put in place according to their policy.

Rationale and Summary:

A CIR was submitted to the Director for resident #001 regarding a fall incident and following this incident, specific restraint was put in place in the written plan of care for falls prevention.

The home's written policy to minimize the restraining of residents includes requiring assessment, written consent, plan of care and monitoring of restraints/PASD prior to implementation and following.

A progress note showed that the substitute decision maker (SDM) for resident #001 agreed with the DOC to use the restraint as a fall intervention, however there was no evidence that the SDM and Registered Staff had completed and signed an Assessment form providing written consent for the physical restraint as required by the homes policy.

A staff member and the Director of Care (DOC) reported that the home was not able to find a Restraint Assessment form and there was no documentation in the

progress notes to support that alternatives were discussed, and what was considered or trialed.

Resident #001's plan of care directed staff to use a specific restraint and to follow the restraint policy and procedure. Point of Care documentation did not consistently document when the restraint was applied and released and that the resident was repositioned or toileted every two hours.

Interviews with two registered staff and the (DOC) confirmed that they were aware of the requirements of the home's restraint policy and acknowledged that they were not following their policy, as they could not find the assessment and consent form for resident #001, and did not have a plan of care and documentation as required by their policy.

Failing to comply with the Restraint policy regarding communicating, implementing and monitoring the safe use of the physical restraint for resident #001, posed a risk of serious bodily harm.

Sources: CIR, Restraint policy, clinical health record, interviews with two registered staff and DOC. [741748]

2. The licensee failed to comply with the home's Restraints policy for resident #006.

Specifically, to ensure completion of the initial assessment form, written consent, plan of care and monitoring was put in place according to their policy.

Rationale and Summary:

A CIR was submitted to the Director for an incident of resident-to-resident abuse involving resident #006. During a review of resident #006's clinical health records there was a physician order for resident #006 to have a specific restraint as needed to prevent them from wandering during an outbreak.

Clinical records had no documentation that the staff of the home discussed or trialed any alternatives prior to using the restraint and there was no consent for the physical restraint signed by resident #006's substitute decision maker (SDM).

The plan of care related to restraints indicated staff were able to use a specific restraint and to follow the restraint policy and procedure.

Point of Care documentation did not identify when the restraint was applied, released and that resident #006 was released and repositioned or if the resident was toileted every two hours.

The Director of Care (DOC) confirmed that the assessment form and consent were not found for resident #006 as required by their Restraint policy.

Failing to comply with the Restraint policy regarding communicating, implementing, and monitoring the safe use of the physical restraint for resident #006, posed a risk of serious bodily harm.

Sources: CIR, Restraint policy, clinical health record, DOC interview. [741748]

3. The licensee failed to comply with the home's Restraints policy for resident #010.

Specifically, to ensure completion with the home's entire Restraint policy and procedure as they did not identify the specific device for resident #010 as a restraint.

Rationale and Summary:

A complaint was received by the home related to the care for resident #010.

During observations of resident #010 they were found to be wearing a specific device applied to their wheelchair. They were unable to follow directions to remove the device when asked. A staff member confirmed that they were often too confused to understand directions.

The consent, assessment, care plan, and monitoring requirements in the Restraint policy had not been implemented for resident #010. Staff failed to complete any assessments indicating if the resident was able to easily remove the safety belt.

The Director of Care (DOC) acknowledged resident #010's use of the device was for safety and acknowledged that the resident had difficulty following directions. The DOC confirmed the expectation of the home's policy is that devices that the resident cannot easily remove would be considered a restraint and the policy should be followed.

Failure to ensure the home's Least Restraint Policy was complied with, posed a significant safety risk for resident #010.

Sources: Clinical records, Least Restraint policy, one staff and DOC interview. [741748]

This order must be complied with by: February 16, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch

Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.