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

Sudbury Service Office Area
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Original Public Report

Report Issue Date: December 13, 2022	
Inspection Number: 2022-1522-0002	
Inspection Type: Complaint	
Licensee: Anson General Hospital	
Long Term Care Home and City: South Centennial Manor, Iroquois Falls	
Lead Inspector Karen Hill (704609)	**Inspector Digital Signature** Karen L Hill Digitally signed by Karen L Hill Date: 2022.12.19 15:39:02 -05'00'
Additional Inspector(s) Inspector #000698 (Justin McAuliffe) attended this inspection during orientation.	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 21-24, 2022

The following intake(s) were inspected:

- One complaint related to concerns about resident care.

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

Resident Care and Support Services
Infection Prevention and Control
Continence Care

INSPECTION RESULTS

WRITTEN NOTIFICATION: Binding on licensees

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that the operational or policy directive that applied to the long-term care home, was complied with.

Rationale and Summary
In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes (LTCHs), effective August 30, 2022, identified that homes must ensure the Personal Protective Equipment (PPE) requirements as set out in the "COVID-19 Guidance Document for LTCHs" or as amended, were followed.

The Ministry of Health COVID-19 Guidance Document, updated October 6, 2022, identified that all staff providing direct care to or interacting with a suspect or confirmed case of COVID-19, should wear eye protection, gown, gloves, and a fit-tested, seal-checked N95 respirator.

At the time of the inspection, an "enhanced" contact and droplet precautions sign, was observed outside of a resident room.

Two staff members were observed in the resident's room and did not wear a N95 mask as indicated on the sign.

Two registered staff members and the Director of Care (DOC) all stated that staff were not required to wear a N95 respirator; that the type of mask to be worn in the room, was up to the staff member's discretion. The home's IPAC lead verified that the staff members should have been wearing a N95 respirator when in the resident's room; that there was a misunderstanding related to the "enhanced" contact and droplet signage that the home had implemented.

There was minimal risk to residents as a result of the improper staff instruction and the selection of PPE by staff who entered a resident room, who was on enhanced contact and droplet precautions for suspected COVID-19.

Sources: Observations of staff; Minister's Directive: COVID-19 response measures for LTCHs, effective August 30, 2022; COVID-19 Guidance Document for LTCHs in Ontario, version 8,

updated October 6, 2022; COVID-19 Guidance: PPE for Health Care Workers and Health Care Entities, Version 1.0 June 10, 2022; and interviews with staff members, IPAC Leads, the Public Health Liaison, and the DOC.

[704609]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that there was a written plan of care for a resident that set out clear direction to staff and others who provided direct care to the resident.

Rationale and Summary
A resident was assessed on their Minimum Data Set (MDS) assessment to have a specific continence care status that required the use of continence care products.

Two months later, a second assessment indicated that a specific continence care product was required for the resident.

The resident's care plan did not include the continence care product.

Two staff members indicated that the resident used different types of continence care products; that the care plan should have indicated what those products were and when they were to be used. The DOC verified that the written plan of care did not provide clear direction related to the products to be used for continence care for the resident.

There was minimal impact to the resident when the home failed to ensure that the plan of care provided clear direction related to the continence care products to be used.

Sources: A resident's health record; the home's policy titled, "Continence Care and Bowel Management Program", revised in 2020; and interviews with staff members, and the DOC.

[704609]

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised when the resident's care needs had changed.

Rationale and Summary
A resident fell while performing an activity of daily living, which resulted in a significant change in their condition.

At the time of the inspection, the resident's care plan indicated that at specified times, the staff were to assist the resident with performing the activity of daily living.

The resident and the staff all stated that since the fall, the resident had not been able to participate in the activity of daily living. The DOC confirmed that when the resident's care needs had changed, the plan of care should have been updated to reflect the change.

There was low risk to the resident, when the care plan had not been revised to reflect the change in the resident's care needs.

Sources: A resident's health record; and interviews with a resident, staff members, and the DOC.

[704609]

WRITTEN NOTIFICATION: Reports re: critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 107 (3) 4.

The licensee has failed to ensure that the Director was informed no later than one business day following an incident that caused an injury to resident which resulted in a significant change in

their health status.

Rationale and Summary
A resident had a fall that resulted in a significant change in their condition.

The Inspector was unable to locate a Critical Incident (CI) report submitted to the Director regarding the resident's fall incident.

The DOC confirmed that a CI report was not submitted to the Director regarding the resident's fall incident.

Failing to report to the Director as required, had no impact on and did not present a risk to the resident’s health, safety, or quality of life.

Sources: Long-Term Care Homes portal; complaint reported to the Ministry of Long-Term Care; the home's policy titled, "Critical Incident Reporting", last revised in 2020; a resident’s health record; and interviews with a resident, staff members, and the DOC.

[704609]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 1.

The licensee has failed to ensure that the IPAC lead designated under O. Regulation 246/22, s. 102 (15), worked in the position, on site at the home, for the required amount of time; in a home with a licensed bed capacity of 69 beds or fewer, at least 17.5 hours per week.

Rationale and Summary
Review of attendance records for a seven-week period, revealed that the designated IPAC lead was not always on site at the home; that when the lead was present, their hours on site could not be verified or did not meet the requirements.

The IPAC lead indicated that they were supporting four other facilities IPAC programs, and acknowledged that they were not always on site, at the home, as required. The DOC could not confirm that the required hours were being met.

There was minimal risk to residents when the licensee failed to ensure the designated IPAC lead was on site, at the home, for the required hours per week, as the home had remote access to the IPAC lead to assist with the delivery of the program when necessary.

Sources: Observations; an IPAC lead's schedule and travel records for a specified period; an IPAC lead's emails on specified dates; IPAC COVID Self-Audit records for specified dates; and interviews with an IPAC lead and the DOC.

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WRITTEN NOTIFICATION: General requirements

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.

The licensee has failed to ensure that the interdisciplinary program required under section 53 of O. Regulation. 246/22, was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Rationale and Summary
The home's policy titled, "Continence Care & Bowel Management Program", was last revised in 2020.

The DOC verified that the program should have been reviewed annually and updated, and was not.

There was minimal risk and minimal impact to the residents, when the home failed to ensure, that at least annually, the home's continence care and bowel management program was

evaluated and updated.

Sources: Home's policy titled, “Continence Care & Bowel Management Program”, last revised in 2020; and interview with the DOC.

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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) (b)

The licensee has failed to ensure that a resident who was incontinent, had an individualized plan to promote and manage their bowel and bladder continence, based on an assessment.

Rationale and Summary
A resident was assessed on their annual Minimum Data Set (MDS) assessment to require specific assistance with toileting.

A review of the resident's health record did not reveal any assessments associated with the plan in place, to assist the resident with toileting.

Registered staff members and the DOC all confirmed that the home did not use an assessment to establish the resident's plan of care, related to toileting.

Failure to ensure that an individualized plan was based on an assessment of the resident, had a moderate impact on the resident and presented a continued risk that changes in their needs would not be identified.

Sources: A resident’s health record; the home's policy titled, "Continence Care & Bowel Management Program", last revised in 2020; and interviews with staff members, and the DOC.

[704609]

WRITTEN NOTIFICATION: Continence care and bowel management program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (h) (iv)

The licensee has failed to ensure that a range of continence care products that promoted continued independence wherever possible, were provided to a resident.

Rationale and Summary
A resident requested to use a specific continence care product to support their independence with continence care.

Staff members confirmed that the resident used the specified product to promote their independence related to continence care; that it was easier for the resident to maintain their continence when they used the product. Staff indicated however, that the home did not provide the specific product for the resident.

The DOC confirmed that the home did not provide the specified continence care product to the resident and should have if it promoted their continued independence.

Sources: A resident's health record; the home's policy titled, "Continence Care and Bowel Management Program", revised in 2022; and interviews with staff members and the DOC.

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WRITTEN NOTIFICATION: Designated lead

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 70 (1)

The licensee has failed to ensure that the home's restorative care program was coordinated by a designated lead.

Rationale and Summary
During the inspection, a lead for the restorative care program was not observed in the home.

Staff and the DOC all verified that the home did not have a designated lead for the program.

Failure to ensure that a designated lead was in place to coordinate the restorative care program in the home, had the potential to impact the residents' abilities to maintain or improve their functional and cognitive capacity.

Sources: Observations; and interviews with staff and the DOC.

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COMPLIANCE ORDER CO #001 - Infection Prevention and Control Program

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (8)

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

Specifically, the licensee shall:

a) Retrain two PSWs and one RPN on the correct procedure for donning and doffing of PPE, including the indications and technique for hand hygiene during the process. Documentation of this training, including who provided the training, the dates of the training, and the content of the training, must be maintained.
b) Conduct audits of staff compliance with the correct procedure for donning and doffing of PPE. The audits must be conducted at least two times a week, on different shifts, and continued for at least four weeks following the service of this order. Copies of the audits must be maintained.

Grounds
Non-compliance with: O. Reg. 246/22, s. 102 (8)
The licensee has failed to ensure that staff participated in the implementation of the IPAC

program, specifically related to the doffing of PPE.

Rationale and Summary
Two PSWs and a RPN exited a resident room on droplet and contact precautions, without following the correct procedure for doffing their PPE or performing hand hygiene when required.

The home's policy titled, “PPE”, last revised in 2022, indicated that staff were to ensure strict adherence to the process of PPE removal. This included the requirement to perform hand hygiene at various points during the doffing process.

The staff members all acknowledged that they had not doffed their PPE correctly. The DOC confirmed that staff were required to follow the process for doffing their PPE as outlined in the home's policy.

Staff failing to doff their PPE correctly when exiting a resident's room who was on contact and droplet precautions, put other residents at moderate risk of contracting a health care associated infection in the home.

Sources: Observations; Signage for Enhanced Contact and Droplet Precautions and doffing of PPE; review of Public Health Ontario: Provincial Infectious Diseases Advisory Committee (PIDAC), Routine Practices and Additional Precautions in All Health Care Settings, 3rd edition, November 2012; home's policy titled, "PPE", last revised in 2022; and interviews with staff members, an IPAC lead, and the DOC

[704609]

This order must be complied with by January 26, 2023

COMPLIANCE ORDER CO #002 - Transferring and positioning techniques

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 79/10, s. 36.

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

Specifically, the licensee shall:

a) Educate all direct care staff/nursing department staff on the different methods used in the transferring of residents and in the ways that the methods are used, to ensure resident safety. Documentation of the training, including who provided the training, the names of the staff trained, and dates of the training, must be maintained.
b) Develop and implement a system to audit staff adherence with the home's policies and procedures and a specified resident's plan of care, related to resident transferring and positioning devices or techniques. Audits must be completed weekly, for a period of four weeks, following the service of this order. A documented record of the audits must be maintained.

Grounds
Non-Compliance with O. Reg. 79/10 s. 36
The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary
A PSW transferred a resident without the assistance of another staff member. The resident fell which resulted in a significant change in their health condition.

Assessments of the resident completed prior to the incident, indicated that the resident required two person assistance with transferring, and that a specified transfer device was to be used.

Two staff members stated that on several occasions, they had transferred the resident with one-person physical assistance; that they were not certain about the resident's transferring requirements, nor when a transfer device was to be used. Additionally, documentation of care provided to the resident around the time of the incident, revealed that several staff members had transferred the resident without the assistance of a second staff member, on many occasions.

There was high impact and high risk to the resident when the home did not ensure that the staff used safe transferring techniques, as the resident sustained a significant injury from the

fall.

Sources: A resident's health record; the home's policy titled, "Transferring-Resident", revised in 2021; and interviews with staff members, and the DOC.

[704609]

This order must be complied with by January 26, 2023

Ministry of Long-Term Care
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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.