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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Amended Public Report Cover Sheet (A2)

Amended Report Issue Date: March 6, 2024
Original Report Issue Date: January 9, 2024
Inspection Number: 2023-1584-0005 (A2)
Inspection Type: Critical Incident
Licensee: The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott
Long Term Care Home and City: St. Lawrence Lodge, Brockville

Amended By Marko Punzalan (742406)	**Inspector who Amended Digital Signature** Marko Punzalan Digitally signed by Marko Punzalan Date: 2024.03.12 13:02:38 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:

The Licensee Inspection Report has been revised to reflect the results of a Director Review (DREV) #0013, based on the decision of the Director.

Non-compliance (NC) #004 and Compliance Order (CO) #001 are rescinded. Administrative Monetary Penalty (AMP) #001 issued with CO #001 is also rescinded.

Non-compliance (NC) #005 and Compliance Order (CO) #002 are rescinded.

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Lead Inspector Marko Punzalan (742406)	**Additional Inspector(s)** Margaret Beamish (000723) Gabriella Kuilder (000726)
Amended By Marko Punzalan (742406)	**Inspector who Amended Digital Signature** Marko Punzalan Digitally signed by Marko Punzalan Date: 2024.03.12 13:03:11 -04'00'

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 27, 28, 29, 30, 2023 and December 1, 5, 6, 7, 8, 2023

The following intake(s) were inspected:

- Intake #00965566 -CIR #M576-0000-43-23. Unexpected death of resident.
- Intake #00100143 – CIR #M576-0000-49-23. Resident to resident alleged physical abuse.
- Intake #00102307- CIR #M576-0000-50-23. Resident fall resulting in injuries.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports of investigation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 27 (2)
Licensee must investigate, respond and act
Reports of investigation
s. 27 (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

The licensee has failed to ensure that the results of the licensee's investigation into an alleged incident of resident to resident alleged physical abuse was reported to the Director.

Rationale and Summary:
An incident of alleged physical abuse between two residents was reported to the Director on a specific date in October 2023. The Critical Incident Report (CIR) was reviewed by the Inspector on a specific date in December 2023 and it noted that the CIR had not been updated with the results of the licensee's investigation.

In an interview, the Director of Care (DOC) acknowledged that the results of the licensee's investigation should have been reported to the Director.

Failing to report the results of the licensee's investigation to the Director, could result in delayed implementation of interventions to protect residents from harm.

Sources: CIR #M576-000049-23, internal investigation file, interview with DOC. [000723]

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that when resident demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours.

Rationale and Summary:
A resident had a history of physically responsive behaviours and was assessed by the Mobile Response Team (MRT) for certain time periods in 2023. The triggers identified by MRT for resident's physically responsive behaviours during that time included cognitive impairment, co-residents and staff in their personal space, boredom, loneliness, pain, and staff shadowing their movements. MRT identified that certain behaviours indicate the resident is in a pleasant mood and identified that quietness indicated either pain or that the resident may become physically responsive.

MRT developed and recommended various interventions for the resident's physically responsive behaviours.

The resident was also assessed by the Geriatric Psychiatry team for their physically and sexually responsive behaviours. In their assessments for certain time periods in 2023, the Geriatric Psychiatry team identified triggers for these behaviours as environmental under/overstimulation, aphasia, and chronic pain. In addition to the pharmacological interventions recommended by the Geriatric Psychiatry team, which were implemented by the home, they also recommended non-pharmacological interventions of redirection, addressing unmet needs, providing

adequate social activity, music therapy, avoiding terms of endearment and keeping them separated from disruptive co-residents.

The identified resident's care plan in Point Click Care and the history of revisions were reviewed for certain periods in 2023. Inspector noted that interventions for resident's responsive behaviours during that time period were to allow the resident to wander in a safe area and to monitor the resident for changes in responsive behaviours and report to registered staff. The kardex posted at the resident's bedside listed the responsive behaviour intervention to allow them to wander in a safe area. The care plans and kardex did not contain all of the non-pharmacological interventions recommended by MRT and the Geriatric Psychiatry team.

A Registered Practical Nurse (RPN), Registered Nurse (RN) and Assistant Director of Care (ADOC) stated staff would look at the care plan in Point Click Care or at the kardex posted in a resident's room to know which interventions to follow for a resident's responsive behaviours. The ADOC and DOC acknowledged that registered staff are responsible for reviewing and updating care plans to include interventions recommended by MRT and the Geriatric Psychiatry team.

Failing to implement all of the strategies recommended by external resources for resident's responsive behaviours, may result in a resident not receiving the interventions they require to help minimize or prevent their responsive behaviours, placing residents at increased risk of harm.

Sources: resident's health records and interviews with RPN, RN, ADOC and DOC. [000723]

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that when resident was demonstrating responsive behaviours, that actions were taken to respond to the needs of the resident including assessment, reassessments and interventions and that the resident's responses to interventions were documented.

Rationale and Summary:

A resident had a history of physically and sexually responsive behaviours. On a specified date in a certain month 2023, resident was started on Dementia Observation System (DOS) behaviour monitoring on days and evenings in addition to having a 1:1 staff member present. The DOS behaviour monitoring was completed by staff until resident was internally transferred to another home area on a specified date on another month 2023.

A review of the DOS sheets on a specific date in a certain month in 2023 to a specific date in another month in 2023, showed that a specific resident demonstrated some physically responsive behaviours and was frequently demonstrating physically affectionate and sexually expressive behaviours towards co-residents. This included the sexual behaviours demonstrated toward a specific

resident.

A previous Assistant Director of Care (ADOC) documented their review of the DOS sheets in a progress note and noted that resident's documented behaviours during that time included kissing and hand holding towards specific residents. The previous ADOC did not document whether any changes were going to be made to resident's plan of care to address the demonstrated behaviours.

Resident's care plan in Point Click Care (and the history of revisions was reviewed for that time period. Inspector noted that the two interventions listed in the responsive behaviours section were implemented prior to the DOS monitoring and there was no evidence of revisions after the DOS monitoring had stopped.

A Registered Practical Nurse (RPN), Registered Nurse (RN) and Assistant Director of Care (ADOC) stated that staff would look at the care plan in Point Click Care or at the kardex posted in a resident's room to know which interventions to follow for a resident's responsive behaviours. RPN acknowledged that at the time of the DOS monitoring for resident, it would have been the previous ADOC's responsibility for reviewing the DOS sheets and determining further interventions required to address the behaviours.

Failing to take action and implement interventions to the responsive behaviours that resident was demonstrating during the DOS monitoring from the identified dates places residents at increased risk of harm.

Sources: resident's health records and interviews with RPN, RN, ADOC and DOC. [000723]

(A2)
The following order(s) has been rescinded: CO #001

COMPLIANCE ORDER CO #001 Duty to protect

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

An Administrative Monetary Penalty (AMP) has been rescinded on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

(A2)
The following order(s) has been rescinded: CO #002

COMPLIANCE ORDER CO #002 Reporting certain matters to Director

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**Non-compliance with: FLTCA, 2021, s. 28 (1) 2.**
Reporting certain matters to Director
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:
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.

COMPLIANCE ORDER CO #003 Infection prevention and control program

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
A. Ensure supplies of personal protective equipment (PPE) is made available and accessible to staff and visitors at point of care when enhanced IPAC control measures are in place.

B. Provide re-education related to enhanced IPAC control measures to Personal Support Workers (PSW) specific to the use of PPE when providing care to residents who are suspected and confirmed of being COVID-19 positive.

C. Revise the resident hand hygiene policy to comply with IPAC Standard (IPAC) Standard for Long-Term Care Homes section 10.1 and 10.2. and 10.3.

D. Complete resident hand hygiene audits for 1 meal service and 1 snack service 2

times per week on each resident home area (RHA). Audits to be completed on separate days, alternating between different meal and snack times for 4 weeks.

E. For all residents requiring additional precautions ensure point of care signage is posted indicating that enhanced IPAC control measures are in place.

F. Written records to be maintained for B, C,D, E until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure the implementation of a standard or protocol issued by the Director with respect to the Infection Prevention and Control Standard for Long Term Care (IPAC Standard), and the COVID-19 Guidance for Public Health Units: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings specifically section 1.2 of the Minister's Directive, which states that LTCHs are required to ensure that masking requirements as set out in the MLTC COVID-19 Guidance are followed.

Summary and Rational

Section 6.1 of the IPAC standard indicates the licensee shall make Personal Protective Equipment (PPE) available and accessible to staff and residents, appropriate to their role and level of risk. This shall include ensuring adequate access to PPE for Routine Practices and Additional Precautions.

On a specific date in December 2023, the Inspector observed contact/droplet precaution signage was posted on the door of a COVID-19 isolation room. It was further noted no PPE was available upon entry to room.

Section 9.1 (d) of the IPAC standard states the licensee shall ensure at a minimum Additional Precautions shall include the proper use of PPE. Home specific outbreak communication directed staff and visitors on the use of N95 masks on outbreak units, and the use of appropriate PPE when entering an isolation room.

Personal Support Workers (PSW) were observed in the room of a COVID-19-positive resident. Point-of-care signage posted on the door of the room indicated contact/droplet precautions were required upon entry. Staff were observed by Inspectors not wearing appropriate PPE. During interviews with PSWs, they acknowledged they were "supposed" to wear gowns and gloves during care, but felt it wasn't necessary as the resident they provided care to was only a suspect case, due to their roommate being Covid-19 positive.

Section 10.1 of the IPAC standards states the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). Section 10. 2 (b) requires providing hand hygiene agent options based on resident preference that adheres to the requirements under requirement 10.1 of the Standard. Additionally, section 10.3 (e) of the Standard indicates residents are to be provided assistance in performing hand hygiene before meals and snacks.

The licensee's Hand Hygiene policy did not include providing residents with access and options for hand hygiene agents based on resident preference that adheres to the requirements under 10.1, and 10.2 of the IPAC Standard. As well the policy did not include providing assistance to the residents in performing hand hygiene before snacks as required under section 10.3 of the IPAC Standard.

Section 9.1 (b) of the IPAC Standard states the licensee shall ensure that Routine Practices are followed in the IPAC program. At minimum Routine Practices shall

include hand hygiene, including, but not limited to the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact). According to the licensee's Hand Hygiene policy staff must perform hand hygiene using alcohol-based hand rub (ABHR) (70-90% alcohol), unless hands are visibly soiled, in which case liquid soap and water will be used, at "The 4 Moments of Hand Hygiene". Additionally, staff are to perform hand hygiene before serving food, and before and after the use of personal protective equipment (i.e., gloves, gown, mask).

On a specific date in December 2023, Activity staff was observed entering and exiting multiple resident rooms, and hand hygiene was not completed. On the same date, the Inspector observed PSW staff distributing snacks to three residents on RHA-Maple. No hand hygiene was performed by staff members before or after serving each resident their snacks.

Section 9.1 (e) of the IPAC standard states at a minimum, Additional Precautions shall include Point-of-care signage indicating that enhanced IPAC control measures are in place.

On a specific date in December 2023, the Inspector observed PPE storage containers were positioned at the entry of multiple resident rooms, however, no signage was posted at point-of-care indicating which enhanced IPAC control measures were required.

Section 6.7 of the IPAC Standard indicates the Licensee shall ensure that all staff, students, volunteers, and support workers comply with applicable masking requirements at all times. The COVID-19 Guidance for Public Health Units: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings

specifically section 1.2 of the Minister's Directive, states that LTCHs are required to ensure that masking requirements as set out in the MLTC COVID-19 Guidance are followed. On November 2, 2023, a memorandum was issued by the Assistant Deputy Minister of Long-Term Care-Operations Division regarding enhanced Masking in Long-Term Care Homes. The memorandum requires staff, students, support workers, and volunteers to wear a mask when they are in an indoor resident area.

On specific dates in a certain month in 2023 in non-outbreak home areas, the Inspector observed two staff with surgical mask positioned below their nose.

By not ensuring compliance with Infection Prevention and Control Standards for Long Term Care specific to the appropriate use and availability of PPE for residents requiring additional precautions, hand hygiene practices for staff and residents, and masking requirements increases the risk of disease transmission amongst residents and staff. **This order must be complied with by** March 08, 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.