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 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: June 15, 2023

Inspection Number: 2023-1014-0003

Inspection Type:
Critical Incident System

Licensee: Arch Long Term Care LP by its General Partner, Arch Long Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation

Long Term Care Home and City: Perth Community Care Centre, Perth

Lead Inspector	**Inspector Digital Signature**
Emily Prior (732)	Emily Prior Digitally signed by Emily Prior Date: 2023.06.29 16:26:56 -04'00'

Additional Inspector(s)
Saba Wardak (000732)
Shevon Thompson (000731)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 24-26, 2023; May 29-31, 2023; and June 1, 2023.

The following intake(s) were inspected:

- Intake #00020386 (CI #0962-000002-23) - Improper/Incompetent treatment of a resident by a staff member related to medication administration
- Intake #00020538 (CI #0962-000003-23) - Alleged staff to resident physical and emotional abuse
- Intake #00022256 (CI #0962-000004-23) - Falls prevention and management
- Intake #00088027 (CI #0962-000011-23) - Unresponsive hypoglycemia of a resident resulting in glucagon and transfer to hospital

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

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

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that a standard issued by the Director with respect to infection prevention and control was implemented.

The Infection Prevention and Control (IPAC) Standard (the "Standard") for Long-Term Care Homes April 2022 was issued by the Director pursuant to section 102(2)(b) of the Regulation under the Fixing Long-Term Care Act, 2021. Additional requirement 5.4 under the Standard indicates that the licensee shall ensure that the policies and procedures for the IPAC program also address: j) Assessment, review, and evaluation of environmental cleaning products; and O.Reg 246/22 s.11(1)(b) requires the licensee to comply with any policy or procedure that is required for under the regulation.

Specifically, the licensee has failed to ensure that environmental cleaning products were checked for expiration as part of their IPAC program.

Rationale and Summary:
On May 24, 2023 Inspector #732 observed a contact precaution room with a yellow hanging personal protective equipment (PPE) caddy on the door. In the caddy was a container of Accel Intervention one minute bacterial wipes. The expiry date noted on the container was November 27, 2022. Inspector #732

observed the same expired bacterial wipes in the yellow PPE caddy the next morning, on May 25, 2023.

In an interview with the Acting Director of Care (DOC), they explained that the staff restocking the floors or the nursing clerks who are ordering the supplies would do checks to ensure that environmental cleaning products, such as bacterial wipes, were not expired prior to being placed on the floor. Furthermore, the Acting DOC described that it is the staff's responsibility working on the floor to ensure that the environmental cleaning products they are going to use are not expired.

Additionally, the licensee's PPE Stock Management Policy indicated that expiration dates must be monitored, and PPE stock should be rotated monthly in accordance to these dates. The procedure indicated to ensure that PPE stock is readily available and replenished on the units and throughout the home as needed, to monitor the PPE stock found on units for expiry dates, and that all expired stock must be discarded.

On May 26, 2023, Inspector #732 observed that the expired Accel Intervention bacterial wipes had been replaced with a new, non-expired container.

Sources: observations of Bathurst Wing; PPE Stock Management Policy #02-01-014, revised July 2022; and interview with the Acting DOC and other staff.
[732]

Date Remedy Implemented: May 26, 2023

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident occurred by staff that resulted in harm or risk of harm to a resident, immediately reported the suspicion to the Director.

Rationale and Summary:
An incident of alleged staff to resident abuse occurred on day shift in February of 2023.

A resident was being toileted when they became aggressive with care. When trying to change the resident's brief they became resistive; kicking, grabbing, and slapping staff. Several staff intervened and the task continued to be performed when the resident refused. The resident was noted to have bruising

to an area of their body. When asked, the Infection Prevention and Control (IPAC) Lead, who responded to the incident shortly after it happened, told Inspector #732 that at that time they thought it could potentially be an incident of staff to resident abuse. Because of this, they told the Administrator right away.

The Director was not informed of the incident until the following evening. The Administrator acknowledged that the incident should have been reported earlier.

Sources: CI 0962-000003-23; INFOLINE-LTC Homes After Hours IL-10122-AH; resident's progress notes; investigation notes; and interview with the IPAC Lead, Administrator, and other staff.
[732]

WRITTEN NOTIFICATION: Training

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (4)

The licensee has failed to ensure that an agency Registered Practical Nurse (RPN) received training on the long-term care (LTC) home's policy to promote zero tolerance of abuse and neglect of residents annually as provided for in O.Reg. 246/22 s. 260 (1).

Rationale and Summary:
The RPN began working at the LTC home in late 2021 and continues to have scheduled shifts. The RPN told inspector #732 that they had not received any training related to the LTC home's policy to promote zero tolerance of abuse and neglect of residents until February of 2023, after an incident occurred that required the RPN to complete additional education.

The Administrator was unable to provide training records showing that the RPN had received training on the LTC home's policy to promote zero tolerance of abuse and neglect of residents for the year 2022.

There is risk to residents' health and safety by not completing the required LTC home's training.

Sources: email from Administrator June 5, 2023; and interviews with RPN #111, Administrator, and other staff.
[732]

WRITTEN NOTIFICATION: Training

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (7) 1.

The Licensee has failed to ensure that an agency RPN, who provided direct care to residents, received training on abuse recognition and prevention annually, as a condition of continuing to have contact with residents as provided for in O.Reg. 246/22 s. 261(2)1.

Rationale and Summary:
The RPN began working at the LTC home in late 2021 and continues to have scheduled shifts. The RPN told inspector #732 that they had not received any training from the LTC home related to the above mentioned area until February of 2023, after an incident occurred that required the RPN to complete additional education.

The Administrator was unable to provide training records showing that the RPN had received training from the LTC home on abuse recognition and prevention for the year 2022.

There is risk to residents' health and safety by not completing the required LTC home's training.

Sources: email from Administrator June 5, 2023; and interviews with RPN #111, Administrator, and other staff.
[732]

WRITTEN NOTIFICATION: Training

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (7) 2.

The Licensee has failed to ensure that an agency RPN, who provided direct care to residents, received training on mental health issues, including caring for persons with dementia annually, as a condition of continuing to have contact with residents as provided for in O.Reg. 246/22 s.261(2)1.

Rationale and Summary:
The RPN began working at the LTC home in late 2021 and continues to have scheduled shifts. The RPN told inspector #732 that they had not received any training from the LTCH related to the above mentioned area until February of 2023, after an incident occurred that required the RPN to complete additional education.

The Administrator was unable to provide training records showing that the RPN had received training from the LTC home on mental health issues, including caring for persons with dementia for the year 2022.

There is risk to residents' health and safety by not completing the required LTC home's training.

Sources: email from Administrator June 5, 2023; and interviews with RPN #111, Administrator, and other staff.
[732]

WRITTEN NOTIFICATION: Training

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (7) 3.

The Licensee has failed to ensure that an agency RPN, who provided direct care to residents, received training on behaviour management annually, as a condition of continuing to have contact with residents as provided for in O.Reg. 246/22 s.261(2)1.

Rationale and Summary:
The RPN began working at the LTC home in late 2021 and continues to have scheduled shifts. The RPN told inspector #732 that they had not received any training from the LTCH related to the above mentioned area until February of 2023, after an incident occurred that required the RPN to complete additional education.

The Administrator was unable to provide training records showing that the RPN had received training from the LTCH on behaviour management for the year 2022.

There is risk to residents' health and safety by not completing the required LTC home's training.

Sources: email from Administrator June 5, 2023; and interviews with RPN #111, Administrator, and other staff.
[732]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The Licensee has failed to ensure that strategies developed for responding to a resident's responsive behaviours were implemented.

Rationale and Summary:
A resident's plan of care described that they could become agitated. On a specific date in February, 2023, the resident was being toileted when they became aggressive with care. Additional staff were called to the resident's room to assist with placing a brief on the resident. When trying to change the resident's brief they became resistive; kicking, grabbing, and slapping staff. Several staff intervened and the task continued to be performed when the resident refused. After the incident, the resident was crying and upset.

Several of the staff involved in the incident indicated that a strategy to respond to the resident's behaviours is to walk away and leave the resident, and then reapproach once they have calmed down. The RPN who was the registered staff involved in the incident, acknowledged that they had not responded with the appropriate strategy.

The Administrator and IPAC Lead confirmed that staff should have left the resident alone, walked away, and reapproached after.

There was undo stress and emotional harm to the resident as a result of continuing to perform care when the resident was agitated and aggressive with staff.

Sources: CI 0962-000003-23; resident's progress notes; investigation notes and statements; and interview with RPN #111, IPAC Lead, Administrator, and other staff.
[732]

COMPLIANCE ORDER CO #001 Administration of Drugs

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

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

- Ensure an identified resident is administered insulin as prescribed;

- Educate RN #116, RPN #117, and RN #118 on medication administration best practices and the Licensee's policy on medication administration, ensuring to include subcutaneous injection administration of insulin;
- Educate RPN #104 on medication administration best practices and the Licensee's policy on medication administration, ensuring to include subcutaneous injection administration of Hydromorphone;
- Document the education, including the date completed and the staff who provided the education (if applicable);
- Perform weekly audits of the above-mentioned staff administering subcutaneous injections for four weeks; and
- Keep a documented record of the audits including the date completed, who completed the audits, the results of the audits, and any follow up with registered staff.

Grounds
The licensee has failed to ensure that a resident was administered a medication in accordance with the directions for use specified by the prescriber.

Rationale and Summary:
The resident was ordered a medication for palliation. The order was to administer 0.5 mg subcutaneously every one hour as needed.

An RPN administered the medication to the resident on a specific date in 2023, four times. It was later discovered that the RPN had made a mathematical error and administered 1 mg of the medication each time, which is double the prescribed dose.

Although there was no harm to the resident at the time of the medication errors, there was risk that the extra medication doses could have affected the resident's health status.

Sources: Resident's electronic Medication Administration Record 2023; Medication Incident Report; CI #0962-000002-23; licensee's investigation notes; and interviews with Administrator and RPN #104
[732]

The licensee has failed to ensure that medication was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary:
A resident was ordered medication to be injected subcutaneously 3 times daily. As per the order, medication was to be held if resident's capillary blood sugar (CBS) level was below 5mmol/L.

Medication was administered to the resident on 6 different occasions even though their CBS level was below 5mmol/L (where medication should have been held).

Although there was no harm to the resident at the time of the medication errors, there was an increased risk of harm as the resident could have suffered from a hypoglycemic event.
Sources: Resident's Electronic Medication Administration Records, interviews with RPN #106 and other staff
[000732]

This order must be complied with by
July 31, 2023

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.