Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date July 15, 2022
Inspection Number 2022_1411_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
St. Peter's Care Centres.

Long-Term Care Home and City
St. Peter's Residence at Chedoke.
125 Redfern Avenue, Hamilton, ON, L9C7W9

Lead Inspector
Jennifer Allen (706480)

Additional Inspector(s)
Yuliya Fedotova (632)

Inspector Digital Signature
Jennifer L Allen
Digitally signed by Jennifer L Allen
Date: 2022.07.18 17:42:10 -04'00'

Inspector #740735 (Sydney Withers) and #C205 (Olive Mameza Nenzeko) were also present during this inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 3, 6-10, 13-16, 20, 22, 24, 27-30, and July 4, 2022.

The following intake(s) were inspected:

- Intake: 007989-22 Critical Incident (CI) #2927-000007-22 related to a self-inflicted injury for which the resident was transferred to the hospital.
- Intake: 009385-22 Complaint related to medication management.
- Intake: 006901-22 Complaint related to hearing aids use and alleged neglect.

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

- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Pain Management
- Reporting and Complaints
- Resident Care and Support Services

- Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: SCREENING

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

Non-compliance with: O. Reg. 246/22, s. 272

The licensee has failed to ensure that all applicable directives, orders, guidance, advice, or recommendations issued by the Chief Medical Officer of Health, or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

Rationale and Summary
As per "Directive #3 for Long-Term Care Homes under the Fixing Long-Term Care Act, 2021" date of issuance May 3, 2022, stated that all staff are actively screened once per day for symptoms and exposure history for COVID-19 before they are allowed to enter the home. The homes must follow the Ministry of Health's COVID-19 Screening Tool for Long-Term Care Homes and Retirement Homes, effective February 16, 2022, for minimum requirements.

Five staff members were observed entering the home and were not actively screened by the screener. The screener did not ask the required active screening questions as per Directive #3. The screening staff stated the screening sheets are prepared in advance with the staff names and they ask the staff if they have any changes or any new symptoms to report and the information on the screening sheet is filled in the later.

A staff member was observed to enter the home. The staff member was observed to walk pass the screener desk, without speaking with the screener. Another staff member confirmed that when they are screened in at the screener desk, the screener does not ask staff all the required screening questions.

According to the ADOC, the staff are required to report to the screener desk as soon they enter the building to complete their active COVID-19 screening. If there is a long line up of staff, the staff can complete passive screening for symptoms only by reading the list of symptoms posted at the front entrance, and then let the screener know that they have read through the questions and what their responses are. The ADOC stated they had made similar observations of staff not approaching the screener desk to be actively screened and had previously brought it to the staff attention not to do this.

The home's COVID-19 Screening Policy dated December 14, 2021, stated the home will ensure that everyone participates in active screening upon entry to the home as per Directive #3. The Screener will record the staff's answers to the questions on the Staff Screening tracking report.

Failure to complete active screening for staff entering the home presented an actual risk of

exposing the residents to COVID-19 or other infectious illnesses.

Sources: Observations of screening; Directive #3 for Long-Term Care Homes under the Fixing Long-Term Care Act, 2021; COVID-19 Screening Policy (COVID-19 Policies, Last Review: December 14, 2021); Interviews with the ADOC and other staff. [706480]

WRITTEN NOTIFICATION: THE STANDARD BY THE DIRECTOR

NC#002 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 ensure that any standard or protocol issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

Rationale and Summary
A. Review of the home's Hand Hygiene (HH) program did not include a process for staff to assist residents to clean their hands before and after a snack.

As per the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes", dated April 2022, the home was required to have a hand hygiene program that includes policies and procedures to support for residents to perform hand hygiene prior to receiving meals and snacks, and support the residents who have difficulty completing hand hygiene due to mobility, cognitive or other impairments.

The Inspector observed five residents who were observed to be capable to feed themselves, being served a snack and drink without being supported with hand hygiene prior to the snack. On another day, another five residents who were observed to be capable to feed themselves, being served a snack and drink without being supported with hand hygiene prior to the snack.

Staff revealed that they did not receive instructions to support residents with hand hygiene prior to serving snacks.

The ADOC and The IPAC and Informatics Manager with Thrive Group, confirmed they were aware of the requirement for HH before and after snacks and stated that the home's expectation for hand hygiene included to support the resident with hand hygiene before and after meals and snacks. The ADOC, reiterated if the resident is capable to feed themselves, support will be provided for hand hygiene to complete the task.

The home's HH program was based on the Just Clean Your Hands (JCYH) program which requires that staff assist residents to clean their hands before and after meals and snacks.

Review of the home's policy titled "Snack Policy – 5-3", last revised October 12, 2021, the procedure identified the residents will be supported by staff to complete hand hygiene prior to their snack.

The failure to have a Hand Hygiene Program in place in accordance with any standard or protocol issued by the Director was a minimal risk to residents related to the possible ingestion of disease-causing organisms that may have been on their hands.

Sources: Observation on the Fir and Cedar Terrace; Observation of snack distribution; PIDAC, Best Practices for Hand Hygiene in All Health Care Settings, 4th edition April 2014; Hand Hygiene Program, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes; Snack Policy (5-3, Last review: October 12, 2021); interviews with the ADOC and the IPAC and Informatics Manager with Thrive Group and other staff. [706480]

B. The licensee has failed to comply with Standard issued by the Director, for the proper use of additional Personal Protective Equipment (PPE) requirements when providing direct care to the residents under additional precautions.

Rationale and Summary
Staff were observed exiting a contact precaution room after providing direct care to the resident without wearing the required additional PPE. The staff stated they would normally wear gloves and gown when providing care but did not on this occasion as the resident was in a rush to receive care.

On another day, staff was observed to enter a droplet precaution room twice. Once to look for the resident and asked them want they wanted to eat for snack and second entry was to place the food and drink on the ledge inside the room, where the resident was waiting, the staff was within two meters of the resident and not wearing the required additional PPE for a droplet precaution room.

The home's Doffing and Donning Surge audits performed by the IPAC and Informatics manager with Thrive Group identified multiple occasions where staff missed donning and doffing of PPE.

Staff stated all staff are expected to follow all the donning and doffing steps outlined on the signage on the front of a resident's room door. Signage on the resident doors provide staff with guidance relating to the steps for donning and doffing PPE which was adapted from the St. Joseph's Healthcare Hamilton.

The ADOC stated that if staff are dropping off nourishment in a droplet precaution room, the staff should be donning and doffing all the additional required PPE when entering the room.

Review of the home's policy titled "Additional Precautions (Isolation) Policy – 4-03", last revised July 11, 2021, indicated that dietary trays can go in and out of a resident's room under additional precautions, that staff must wear PPE as directed by additional precautions signage for tray delivery.

Failure to don and doff additional precaution PPE increased the risk of other residents contracting a contagious disease.

Sources: Observations on the Fir and Cedar Terrace, Doffing and Donning Surge audits; Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April 2022); Additional Precautions (Isolation) Policy (4-03, dated July 11, 2021), interviews with the ADOC and other staff. [706480]

WRITTEN NOTIFICATION: FOUR MOMMENTS OF HAND HYGIENE

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee failed to ensure that all staff participated in the implementation of the Infection Prevention and Control Program when staff did not perform Hand Hygiene (HH) as per the required Four Moments of Hand Hygiene when entering and exiting the resident environment.

Rationale and Summary
Staff was observed not performing HH when they exited the resident's environment, where they removed dirty dishware from the resident room. The same staff was observed to not perform HH when exiting a resident environment and directly entering another resident's environment.

Staff stated they have received training on The Four Moments of Hand Hygiene through Surge Learning and online videos and there are posters posted everywhere regarding the four moments of HH to remind staff. Another staff member corroborated that staff received training for hand hygiene annually.

On review of the home's COVID-19 self-assessment audits, documentation was noted stating there were missed moments of hand hygiene in relation to the home's Four Moments for Hand Hygiene practices and immediate corrective coaching was provided.

Review of the home's SpeedyAudit Ministry of Health (MOH) report of the Four Moments of Hand Hygiene, identified a 73.3% compliance rate for hand hygiene before entering the patient environment, and an 88.5 % compliance rate for hand hygiene after leaving the patient's environment.

Failure to perform HH when exiting or entering a resident's environment may increase the risk of resident exposure to infectious illnesses.

Sources: Observations on Cedar Terrace; COVID-19 self-assessment audits; SpeedyAudit Ministry of Health (MOH) report; Interviews with staff. [706480]

WRITTEN NOTIFICATION: CARE NEEDS CHANGED

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (10) (b)

A. The licensee has failed to ensure that when a resident's health care needs changed, they were reassessed.

Rationale and Summary
On a day in March 2022, there was documentation in the progress notes that a resident's family reached out to the nursing staff relating to their concerns about the resident. The nurse initiated a Dementia Observation System (DOS) monitoring and added the family's concern to the physician communication book for further assessment.

Review of the resident's admission documentation revealed that a specific assessment indicated that the resident had a history related to this concern. The InterRAI Home Care Assessment Form completed by the Home Community Care Support Service (HCCSS), stated a family member reported the resident had demonstrating this same concern.

Review of the physician communication book, there was indication that the physician had received the concern, documented by a check marked on the resident name on the physician communication sheet, however there was no follow up relating to the family concern.

The DOS monitoring initiated by the nurse had two entries completed. Days three, four, five, six, and seven on the DOS monitoring form were not completed.

A register staff member confirmed that family expressing their concerns to the home is considered a change in the resident care needs and warranted further assessment.

There was a moderate risk to the resident. When their care needs changed, and those needs were not assessed at the time of change. Further assessment at the time of concern may have alerted the home to the resident's increasing risk.

Sources: Progress notes, Physician communication book; Point Click Care online assessments Home Community Care Support Service documentation, DOS monitoring flow sheets; Interviews the DOC and other staff. [706480]

B. The licensee has failed to ensure that a resident's plan of care was reassessed and revised when care set out in the plan was no longer necessary.

Rationale and Summary
A resident's care plan included an intervention that was no longer necessary and applicable to the care of the resident. The resident's care plan identified an intervention that the resident should be having blood work to monitor drug levels in their blood as per physician orders. According to the most recent Order Review Report, the laboratory orders do not include any drug level monitoring. The resident's Medication Administration Record did not reveal any medications that would warrant blood level monitoring.

Interview with the DOC confirmed upon their review of the resident's medications the resident was not taking any medications that would require blood work monitoring.

Failure to update the resident care plan was a minimal risk to the resident as the intervention was not being followed and the resident did not have invasive blood drawn.

Sources: MAR, Order Review Report, care plan and interview with the DOC.

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 101 (1) (2)

The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows: 2. For those complaints that could not be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint should be provided within 10 business days of receipt of the complaint including the date by which the complainant could reasonably expect a resolution, and a follow-up response that complied with paragraph 3 shall be provided as soon as possible in the circumstances.

Rationale and Summary
A complaint was submitted to the MLTC, related to a concern about medication management for a resident.

Communication with the complainant documentation identified that the follow up with a complainant was conducted 18 days later after the complaint was received by the home.

During the inspection, the DOC confirmed that the home did not provide an acknowledgement of the receipt of the complainant within 10 business days related to the complaint could not be investigated and resolved within 10 business days.

Sources: Complaint intake (IL-01282-HA), complaint documentation records; interview with the DOC. [632]

WRITTEN NOTIFICATION: 24-HOURS ADMISSION CARE PLAN

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 24 (1) (5)

The licensee has failed to ensure that a resident's care plan included, at a minimum, the following with respect to the resident: 5. Drugs and treatments required.

Rationale and Summary
The Discharge Medication plan and prescription for a resident, directed staff to start a specific medication when the specific blood test result was within a desired range.

The MD Communication Sheet identified under the nature of concerns/issues heading, that the resident was a new admission and for the physician to review the specific medication order.

The resident's 24-hour plan of care documentation did not identify interventions related to the specific blood testing and specific medication administration conditions for the resident, which was confirmed by staff.

The home's Prescriber/Physician Order indicated that medication orders, such as lab tests, might be included on the ePhysician/Prescriber Order Review (POR) as agreed by the Home and the Pharmacy and the Prescriber indicated whether each order was to be continued or discontinued.

The resident was at potential risk of complications related to their health status as a result of the required specific blood test and specific medication that were not included in their 24 hours plan of care.

Sources: Resident's plan of care documentation, Discharge Medication plan and prescription, MD Communication Sheet, Prescriber/Physician Order Policy; interviews with staff. [632]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO THE DIRECTOR

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 24 (1)

The licensee has failed to ensure that a person who had 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 was based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Rationale and Summary
A complaint was submitted to the Ministry of Long-Term Care (MLTC) related to a concern about medication management for a resident.

The home did not report to the MLTC the suspicion and the information upon which it was based to the Director related to improper or incompetent treatment or care of the resident that resulted in harm or a risk of harm to the resident.

The DOC confirmed that the MLTC was not immediately informed about the suspicion of improper or incompetent treatment of the resident, which came as a result of a complaint.

Sources: Complaint intake(#IL-01282-HA), MLTC Critical Incident System; interview with the DOC. [632]