Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 27, 2021	2021_805638_0006	023627-20	Critical Incident System

Licensee/Titulaire de permis

Corporation of the Town of Kirkland Lake
3 Kirkland Street West Postal Bag 1757 Kirkland Lake ON P2N 3P4

Long-Term Care Home/Foyer de soins de longue durée

Teck Pioneer Residence
145A Government Road East Postal Bag Service 1757 Kirkland Lake ON P2N 3P4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 10 - 14, 2021.

The following intake was inspected upon during this Critical Incident System (CIS) inspection:
-One log which was related to a fall resulting in a significant change in status.

Complaint inspection #2021_805638_0007 was conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Infection Prevention and Control (IPAC) Lead, Lead Housekeeper, Housekeeping staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Restorative Care Coordinator/Life Enrichment Manager, Timiskaming Public Health Unit, residents and their families.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, IPAC practices, staff to resident interactions, reviewed relevant health care records as well as policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the hand hygiene program maintained access to point-of-care hand hygiene agents, which did not allow staff to participate in the

implementation of the infection prevention and control program.

Public Health Ontario (PHO), Provincial Infectious Diseases Advisory Committee's (PIDAC) “Best Practices for Hand Hygiene in All Health Care Settings. 4th Edition, April 2014” outlines Alcohol Based Hand Rub (ABHR) should be located at point-of-care, the place where three elements occur together: the resident, the health care provider and care or treatment involving resident contact. In some areas, staff may need to carry ABHR for their own use when it cannot be installed or when point-of-care hand hygiene is more easily accessible.

The home's policy titled infection prevention and control subject hand hygiene last reviewed May 2020, outlined that hand hygiene with ABHR at the point-of-care is the preferred method of hand hygiene in LTC with a few exceptions. Point-of-care refers to the place where the resident, the health care worker and the care procedure come together. ABHR should be accessible without leaving the patient zone and are generally placed within arms reach of the health care worker. Instances when hand hygiene should be performed during the delivery of healthcare have been simplified into four key moments; 1. Before initial resident/resident environment contact, 2. Before aseptic procedures, 3. After body fluid exposure risk and 4. After resident/resident environment contact.

During a tour of a unit, the Inspector observed ABHR in the dining room, on the medication cart, in two resident rooms and behind the nurses station. There was no ABHR inside or near 15 resident rooms, nor an easily accessible areas where resident interactions would occur.

The Inspector observed;
-Two staff members moving between resident rooms, come into contact with residents and their environment without hand hygiene in between interactions;
-A staff member provide a treatment to a resident, not have ABHR available and subsequently touch the treatment cart and enter the medication room, coming into contact with the door handle and punch code, to access ABHR; and,
-A staff member carrying soiled linens without gloves, then attend to another resident, touch hand rails while walking down the hallway and coming into contact with door punch codes without hand hygiene being performed between these tasks.

Staff were not observed to have had ABHR on themselves nor had any been used during these observations. Two staff members identified they did not carry any ABHR on

themselves, despite the lack of availability on the unit. The DOC identified they had reviewed this concern as well and there had never been ABHR placed near resident rooms due to behavioural concerns.

The lack of available ABHR and staff implementation of hand hygiene presented a risk of exposing residents to infectious agents.

Sources: Inspector observations; PHO PIDAC “Best Practices for Hand Hygiene in All Health Care Settings. 4th Edition, April 2014"; the home's Infection prevention and control hand hygiene policy last reviewed May 2020; Interviews with the DOC and other staff. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the IPAC program, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe environment related to the failure to maintain infection prevention and control measures specified in Directive #3, regarding universal masking in order to protect residents from COVID-19.

Directive #3 stipulated that all staff and visitors must always comply with universal masking and must wear a medical mask for the entire duration of their shift/visit. As per the requirements, staff were required to comply with universal masking at all times, even when they were not delivering direct patient care, including in administrative areas. Masks must not be removed when staff were in contact with residents and/or in designated resident areas.

Inspector observed a staff member with their mask pulled down under their chin. The staff member brought a resident to the telephone behind the nurses station and spoke to the resident within one meter of their space, with their mask pulled down. The staff member replaced their mask after a couple minutes had passed while speaking directly to the resident, within a two meter distance. The staff member identified that they were talking on the phone with the resident's family and pulled down their mask at that time and forgot to bring it back up.

The lack of implementation of universal masking while in direct contact with a resident presented a risk of exposing the resident to COVID-19.

Sources: Inspector observation; Directive #3 (version effective as of May 4, 2021); Interviews with the DOC and a staff member. [s. 5.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when two residents fell, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A resident sustained falls on two separate instances. No post falls assessments were identified related to these falls within the Point Click Care (PCC) electronic records. An RPN identified that whenever a resident falls, the registered staff assess the resident, which is documented in PCC. The RPN identified every single fall required a post fall assessment be done.

In an interview with the DOC, they identified that staff have to implement the home's falls program fully and staff should be using the post fall tool and completing in it entirety after a resident falls.

Sources: Resident health care records; assessments; progress notes; the home's Fall Prevention and Management Program reviewed May 2020; interviews with the DOC and other staff. [s. 49. (2)]

2. A second resident sustained falls on two separate instances. No post falls assessments were identified related to these falls within the PCC electronic records.

In a review with the DOC, they were unable to locate or identify a post falls assessment specific to the falls the resident sustained.

Sources: Resident health care records; assessments; progress notes; the home's Fall Prevention and Management Program reviewed May 2020; interviews with the DOC and other staff. [s. 49. (2)]

Issued on this 27th day of May, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.