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

Toronto District
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Original Public Report

Report Issue Date: January 24, 2024
Inspection Number: 2024-1427-0001
Inspection Type: Complaint Critical Incident
Licensee: Regency LTC Operating Limited Partnership, by it general partners, Regency Operator GP Inc. and AgeCare Iris Management Ltd.
Long Term Care Home and City: AgeCare Westbury, Etobicoke

Lead Inspector	**Inspector Digital Signature**
Noreen Frederick (704758)	Noreen Frederick Digitally signed by Noreen Frederick Date: 2024.02.07 15:18:09 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 9, 10, 11, 12, 15, 16, 2024

The following intake(s) were inspected:

- Intake: #00101510 - [CI: 2943-000013-23] - COVID-19 outbreak
- Intake: #00104297 - Complaint related to unexplained bruising

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

Resident Care and Support Services
Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and wound care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident received a skin assessment of their altered skin integrity by a member of the registered nursing staff, using a clinically appropriate assessment instrument.

Rationale and Summary
(i) A resident was observed with an altered skin integrity of an unknown cause. Registered Practical Nurse (RPN) stated that when they first observed the altered skin, they did not complete an initial skin and wound assessment.

The Director of Care (DOC) stated that initial skin and wound assessment should have been completed for the resident on the day altered skin was first observed.

When the home did not complete an initial skin and wound assessment of the resident's altered skin, there was risk of further complications related to the impaired skin integrity and delay in treatment initiation.

Sources: Review of resident's clinical records, and interview with RPN, and DOC.

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Rationale and Summary
(ii) A resident was observed with an altered skin integrity in two different areas of their body. Review of skin and wound assessments revealed that an initial skin and wound assessment of the resident's altered skin was not completed. RPN stated that when they first observed the resident with altered skin integrity, they did not complete the initial skin and wound assessment. The Skin Care Coordinator and the DOC both stated that initial skin and wound assessment should have been completed for the resident on the day it was first observed.

When the home did not complete initial skin and wound assessment of the resident's altered skin integrity, there was risk of further complications related to the impaired skin integrity and delay in treatment initiation.

Sources: Review of resident's clinical records, and interview with RPN, Skin Care Coordinator and DOC.

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WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee failed to ensure that a resident was reassessed at least weekly by a member of the registered nursing staff when they exhibited altered skin integrity.

Rationale and Summary
(i) A resident was observed with an altered skin integrity of an unknown cause. Review of weekly skin and wound assessments revealed that the registered staff did not complete three weekly skin assessments.

The DOC stated that registered staff were required to complete skin and wound assessments on a weekly bases.

Failure to complete weekly skin and wound assessment put the resident at risk for further alteration/deterioration of skin integrity.

Sources: Review of resident's clinical records, and interview with DOC.

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Rationale and Summary

(ii) A resident was observed with an altered skin integrity of unknown cause on two different location on their body. Review of weekly skin and wound assessments and Electronic Treatment Administration Record (ETAR) revealed that one weekly skin and wound assessment was not completed. The Skin Care Coordinator and DOC both acknowledged that weekly skin and wound assessment should have been completed.

Failure to complete weekly skin and wound assessment put the resident at risk for further alteration/deterioration of skin integrity.

Sources: Review of resident's clinical records, and Interview with Skin Care Coordinator and DOC.

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WRITTEN NOTIFICATION: Pain management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 2.

Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.

The licensee has failed to ensure that strategies to manage the pain, including non-pharmacologic interventions were implemented and complied with for a resident.

Rationale and Summary
A resident was observed with an altered skin integrity of an unknown cause. Review of progress notes revealed that the resident experienced pain with change of position, transferring, and was guarding the injury site. The next day, the resident continued guarding their injury site during transferring and movement. Electronic Medication Administration Record (EMAR) revealed that no pain medication was administered to the resident. RPN stated that they were aware that the resident experienced pain however they did not administer pain medications. Furthermore, they stated that no non-pharmacological interventions were implemented for the resident's pain.

The DOC acknowledged that the staff were expected to treat the resident's pain using pharmacological as well as non-pharmacological interventions..

Failure to treat the resident's pain caused the resident unnecessary distress and discomfort.

Sources: Resident's clinical records, and interviews with RPN and DOC.

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WRITTEN NOTIFICATION: Pain management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)

Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically

appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary
A resident experienced pain on their injury site. The resident had an analgesic order and Registered Nurse (RN) administered this medication to the resident, however the pain medication was ineffective as documented on the EMAR. RN stated that when the resident's pain was not relieved by initial intervention, they did not assess the resident using a clinically appropriate assessment instrument.

The DOC acknowledged that staff were expected to assess the resident related to their pain using a clinically appropriate assessment instrument when their pain was not relieved with initial intervention.

Failure to complete a pain assessment using a clinically appropriate assessment instrument when the resident's pain was not relieved by initial intervention, put them at risk of not receiving appropriate pain relief interventions.

Sources: Resident's EMAR, and interviews with RN and DOC.

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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 (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 licensee has failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Specifically, Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, s. 10.1 states that the licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

Rationale and Summary
(i) On January 9, 2024, Inspector found a total of two expired hand sanitizers in use in two different residents' rooms. IPAC Lead acknowledged that the expired product should have been replaced.

Due to the Long-Term Care Home (LTCH) using expired hand sanitizers, there was a risk of infection transmission as they may have been less effective against pathogens.

Sources: Inspector's observations, interview with IPAC Lead, and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023).

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Specifically, IPAC Standard for Long-Term Care Homes, s. 9.1 (b) states that the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At minimum routine practices shall include: hand hygiene, including, but not limited to, at 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).

Rationale and Summary
(ii) On January 9, 2024, an RN was observed entering a resident's room to take their vital signs and then exiting their room. The RN did not perform hand hygiene before or after resident/resident environment contact and acknowledged inspector's observations. IPAC Lead stated that staff were required to perform hand hygiene before and after resident/resident environment contact.

Due to the Staff's failure to follow proper hand hygiene practices, there was risk of infection transmission.

Sources: Inspector's observations, interviews with RN and IPAC Lead, and IPAC standards for Long-Term Care Homes, April 2022 (Revised September 2023).

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WRITTEN NOTIFICATION: Reports re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (2)

Reports re critical incidents
s. 115 (2) Where a licensee is required to make a report immediately under subsection (1) and it is after normal business hours, the licensee shall make the report using the Ministry's method for after hours emergency contact. O. Reg. 246/22, s. 115 (2).

The licensee has failed to ensure that the Director was immediately informed after normal business hours, using the Ministry's method after hours emergency contact when an outbreak of a disease of public health significance occurred in the home, specifically COVID-19 outbreaks.

Rationale and Summary
A Critical incident System (CIS) report was submitted to the Director and indicated that public health declared a COVID-19 outbreak on November 9, 2023 at 1600 hours. The report was submitted on November 9, 2023, at 1720 hours however, LTCH did not contact the Ministry's method of after hours emergency. IPAC Lead acknowledged that the home should have contacted the Ministry using after hours emergency method.

Failure to use Ministry's method of after hours emergency did not place residents at risk.

Sources: CI #2943-000013-23, and interview with IPAC Lead.

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