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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: August 3, 2023

Inspection Number: 2023-1477-0005

Inspection Type:
Complaint
Critical Incident System

Licensee: 859530 Ontario Inc. (operating as Jarlette Health Services)

Long Term Care Home and City: Royal Rose Place, Welland

Lead Inspector	**Inspector Digital Signature**
Nishy Francis (740873)	Nishy Francis Digitally signed by Nishy Francis Date: 2023.08.17 09:56:41 -04'00'

Additional Inspector(s)
Jonathan Conti (740882)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 17-21, 24-28, and 31, 2023.

The following intakes were inspected in this Critical Incident (CI) inspection:

- Intake #00004062 - [CI: 3049-000058-22], #00005033 - [CI: 3049-000060-22], and #00088547 - [CI: 3049-000038-23] related to catheter care.
- Intake #00004217 - [CI: 3049-000062-22] related to hypoglycemia management.
- Intake #00017724 - [CI: 3049-000002-23] and #00020193 - [CI: 3049-000013-23] related to abuse and neglect.
- Intake #00022335 - [CI: 3049-000020-23] related to skin and wound prevention.
- Intake #00084320 - [CI: 3049-000023-23] related to resident care and services.
- Intake #00090156 - [CI: 3049-000043-23] related to falls prevention and management.

The following intake was inspected in this complaint inspection:

- Intake #00087954 compliant related to concerns of resident care and services.

The following intakes were completed in this CI inspection: #00090569-23 - [CI: 3049-000044-23], #00088414-23 - [CI: 3049-000036-23], and #00086539-23 - [CI: 3049-000032-23] related to falls prevention and management.

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

Resident Care and Support Services
Continence Care
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

Section 7 of the Ontario Regulation 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or wellbeing, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

A) The licensee has failed to ensure that a resident was protected from neglect.

Rationale and Summary
Co-DOC (Co-Director of Care) confirmed a resident was admitted to the home with a medical device, and a physician's order to change the medical device was not completed. Co-DOC also confirmed an admission assessment was completed which did not address the resident's medical device. Co-DOC confirmed the resident's medical device should have been changed at least three times from the time of admission to discharge. The home was unable to produce documentation that the resident's medical device was changed.

There was a potential risk of infection for the resident when the medical device was not changed.

Sources: Review of the resident's clinical record; interviews with the co-DOC.

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B) The licensee has failed to ensure that a resident was protected from neglect.

Rationale and Summary
A resident had a history of an identified infection and treatment with use of a medical device. Specifically, the resident was admitted to the home with an order to have a medical device changed monthly. During the resident's admission process, the order was not transcribed into the resident's electronic medication administration record (eMAR) or into their care plan by the admitting registered staff.

A registered staff and co-DOC acknowledged that orders to change the medical device were not transcribed exactly as written by the prescriber onto the eMAR. Staff acknowledged the medical device was not changed based on documentation and internal auditing.

Co-DOC and DOC confirmed it is the responsibility of the registered staff to ensure orders made by the physician are transcribed exactly as ordered into eMAR and to be put into the resident's care plan for direct-care staff to have access to.

Staff acknowledged the safety of the resident was jeopardized by the medical device changes not being transcribed into the plan of care as ordered by the physician. There was a potential risk of infection for the resident when medical devices changes were not completed as required to maintain the health and wellbeing of the resident.

Sources: the home's LTC Physician Orders- Transcription (routine and stat orders) policy, last revised July 5, 2022; resident clinical record including progress notes, care plan, eMAR, continence assessment; interviews with registered staff, co-DOC and DOC.

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WRITTEN NOTIFICATION: Directives by Minister

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The Licensee has failed to ensure that where the Act required the Licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with.

Rationale and Summary
In accordance with the Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia, effective April 15, 2022, the Licensee was required to ensure that corrective actions were taken as necessary for a resident's severe hypoglycemia incident.

The home's policy titled LTC Emergency Care- Hypoglycemia defines severe hypoglycemia as when the individual requires assistance of another person, that unconsciousness may occur, and blood glucose is less than an identified level. The corrective action for a resident that has severe hypoglycemia and is unconscious is that a medication should be administered as per orders, in addition to transfer to hospital for assessment, and treatment if required. The homes definition of severe hypoglycemia outlines that unconsciousness may occur, and that a medication should be administered as per orders.

A resident had an order for an identified medication as needed (PRN) for blood sugar less than an identified level and if the resident is unable to swallow.

On an identified date, the resident was assessed by the co-DOC due to reports from staff that the resident was showing signs of hypoglycemia. Vitals were taken by registered staff, and two repeat readings for blood glucose indicated low blood sugar. Staff had attempted to provide the resident with juice to drink as an oral glucose treatment for severe hypoglycemia, however, were unsuccessful as the resident refused the drink.

Co-DOC called the physician and orders were obtained to call emergency medical services (EMS) for transfer of resident to the hospital. EMS arrived and retested the resident's blood glucose levels. Due to a low blood glucose reading, an identified medication was administered by the paramedics prior to transfer to hospital.

At the time of incident, co-DOC was not aware that the resident had an order for the identified medication. Co-DOC and DOC confirmed that based on the resident's hypoglycemia with unsuccessful attempt at oral glucose, as well as the home's policies, that the resident's ordered medication should have been administered by the home's registered staff.

By the licensee not following the Minister's Directive for taking the corrective actions as necessary to provide medication as ordered when resident was experiencing severe hypoglycemia, there may have been a risk of harm to the resident's health status and wellbeing.

Sources: Minister's Directive: Glucagon, Severe Hypoglycemia and Unresponsive Hypoglycemia, dated April 11, 2022; resident's clinical files including progress notes, eMAR; pharmacy incident number RROSE_2207_002; interview of Co-DOC and DOC; the homes LTC Administration of Medications including PRN Medications policy, last revised May 3, 2022; the home's LTC Emergency Care-Hypoglycemia policy, last revised June 20, 2022.

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WRITTEN NOTIFICATION: General Requirements

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

Non-compliance with: O. Reg. 246/22, s. 34 (1) 2.

The licensee has failed to ensure that where, under the program, staff used any devices with respect to a resident, the devices were appropriate for the resident based on their condition.

Rationale and Summary
A registered staff assessed a resident and noted their medical device was not functioning. The registered staff performed routine interventions to remove the medical device without success. The registered notified the DOC and another registered staff, and the resident was sent to hospital where the medical device was removed.

The registered staff admitted to using an intervention that was not in the current best practice or policy. Another registered staff stated concerns for the resident's safety and that the intervention used was not appropriate.

The DOC stated that the registered staff attempted an intervention that was not included in best practice guidelines as referenced in the policy.

Sources: Review of resident's clinical record, home's policy on catheter care, last revised June 21, 2022; interviews with separate registered staff, and the DOC.

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WRITTEN NOTIFICATION: Attending Physician or Registered Nurse (Extended Class)

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 88 (1) (c)

The licensee has failed to ensure that a physician participated in the provision of on-call coverage.

Rationale and Summary
A complaint was submitted to the Ministry of Long Term Care (MLTC) that on an identified date, a resident waited several hours for a medication. The resident's Substitute Decision Maker (SDM) reported to the MLTC that they approached at least three different staff specifically for a medication. Two registered staff confirmed speaking to the SDM on the identified date.

The home utilized an electronic process of communication between registered staff and Physicians

regarding resident care needs. The home's policy on electronic communication stated physicians were to login to the secured application and reply to staff messages with follow up direction or requests for further information. A registered staff member sent two secure messages to the on-call physician on the identified date. The physician did not provide a response to the messages for several hours.

The DOC stated physicians had a responsibility to have the electronic communication application open at appropriate times, check the application for staff messages, and provide timely responses. The DOC confirmed that when the physician on-call did not respond in a timely manner, they failed to participate in the provision of on-call coverage.

Sources: Record review of resident's clinical record, and the home's policy on Secure Conversations, last revised May 7, 2022; interview with registered staff and the DOC.

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COMPLIANCE ORDER CO #001 Duty of licensee to comply with plan

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

1. Educate all Personal Support Worker (PSW) staff on a specified home area regarding the use of an identified adaptive aid for residents, and the home's expectation of staff for supervising residents that require the use of the identified adaptive aid; and
2. Document the education, including the dates, names of PSWs receiving education, and the staff member(s) who provided the education; and
3. Keep a record of the documentation of the education for inspector review.

Grounds

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified.

Rationale and Summary

A resident had a specific transferring plan of care intervention, that staff were to provide supervision in common areas to ensure safe transfers and use of gait aid. The resident's plan of care further stated for staff to ensure use of assistive devices for ambulation.

On an identified date, the resident self-transferred from their dining room table post-morning meal without their gait aid and sustained an unwitnessed fall, which resulted in hospitalization and injury.

The resident was found by the co-DOC and staff #106, and after assessment they were transferred to hospital. Internal investigation notes and interviews with staff confirmed that other staff members were not in the dining area and the resident was not supervised when in the common area at the time of fall.

DOC and staff #105 confirmed that the expectation of staff was to provide the resident with their gait aid when in a common area such as the dining room and to remind the resident to use their gait aid when walking. Staff acknowledged that the gait aid was at the dining table with the resident prior to fall, but the supervision to ensure safe transfer was not there in place.

The resident was put at an increased risk for injury when they were not supervised for use of their gait aid as required by their plan of care. By the resident not having supervision, a safe transfer was not ensured and the resident had a subsequent fall and injury.

Sources: resident's clinical records including care plan, physiotherapy assessment, progress notes; home's internal investigation notes; interviews with staff #105, #106, co-DOC; home's policy and procedure LTC Falls Prevention and Management- Program, last revised April 10, 2023.

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This order must be complied with by

September 13, 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.