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
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Original Public Report

Report Issue Date: April 5, 2024

Inspection Number: 2024-1477-0001

Inspection Type:
Complaint
Critical Incident

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

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

Lead Inspector	**Inspector Digital Signature**
Emily Robins (741074)	Emily C Robins Digitally signed by Emily C Robins Date: 2024.04.11 09:58:28 -04'00'

Additional Inspector(s)
Cathy Fediash (214)
Kerry O'Connor (000769)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: February 21-23, 26-29, 2024 and March 1, 4-8, 2024.

The following intakes were inspected:

- Intake: #00102023 [Critical Incident (CI) #3049-000076-23] - Improper/incompetent treatment of a resident by staff.
- Intake: #00106097 [CI #3049-000005-24] - Falls prevention and management.

- Intake #00105982 [CI #3049-000004-24] and complaint intake #00106018 - Unexpected death of a resident.
- Intake: #00108400 [CI #3049-000015-24] - Prevention of abuse and neglect.
- Intake: #00108547 [CI #3049-000016-24] - Infection Prevention and Control.
- Intake #00109404 [CI #3049-000019-24], and complaint intake #00109408 related to prevention and abuse and neglect and skin and wound program.

The following intakes were completed with this inspection:

- Intakes #00103034 [CI #3049-000080-23], #00105159 [CI #3049-000085-23] related to Falls prevention and management.
- Intakes #00105103 [CI #3049-000084-23], #00105510 [CI #3049-000001-24], #00105571 [CI #3049-000003-24], and #00107514 [CI #3049-000011-24] related to Infection Prevention and Control.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive Behaviours

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible

The licensee failed to ensure that strategies for a resident's responsive behaviours were developed and implemented.

Rationale and Summary

A resident had a known history of responsive behaviours. The resident's current plan of care did not include their responsive behaviours, or any strategies that had been developed or implemented to respond to these behaviours.

Failure of the home to develop and implement strategies for known responsive behaviours put the resident's safety, security and needs at risk of not being met.

Sources: Current plan of care, critical incident report, interviews with staff [000769].

WRITTEN NOTIFICATION: Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care

s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to ensure that staff involved in the activities of daily living (ADL) care needs of a resident collaborated with each other in the development of the plan of care so that the care was integrated, consistent and complemented each other.

Rationale and Summary

A resident had known responsive behaviours. The resident's electronic Medication Administration Record (eMAR) contained a nursing order, in which registered staff were to remind other staff each morning to ensure the resident's morning care was completed. The other staff were to report to registered staff if care was refused and registered staff would then complete a progress note.

The resident's electronic care plan did not include the above requirements. Staff indicated they had written the nursing order on a specified date. They confirmed that the nursing order had not been implemented into the resident's care plan to ensure that these aspects of the resident's care were consistent, integrated and complimented each other.

When the plan of care is not integrated, consistent or complements each other, there is the potential for care requirements to be missed, or not provided as intended.

Sources: Critical Incident report, resident's eMAR, electronic care plan and interviews with staff [214].

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A) The licensee failed to ensure that a resident's interventions in place for their responsive behaviours, had been provided as set out in their plan of care.

Rationale and Summary

The resident had known responsive behaviours. Their plan of care included an intervention to manage this behaviour.

Observation of the resident's bedroom and confirmation by staff, identified these interventions had not been in place, as specified in the resident's plan of care.

When the responsive behaviour plan of care is not provided as specified, this has the potential to not meet the resident's assessed needs, and may result in the potential of their behaviours to not be managed.

Sources: Resident's plan of care, observations of their bedroom and interviews with staff [214].

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

Rationale and Summary

A resident's plan of care specified that staff were to position the resident in bed as medically advised. Inspector observed the resident in bed and the intervention was not in place. Staff indicated that this intervention was still current at the time of the observation.

Failure to ensure that care was provided to the resident as specified in their plan of care put the resident at risk.

Sources: Resident's care plan, observation of resident and interviews with staff [741074].

WRITTEN NOTIFICATION: Documentation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee failed to ensure that the provision of the care set out in the plan of care for a resident was documented.

Rationale and Summary

The resident's plan of care specified an intervention to prevent skin breakdown.

On a specified date, no documentation was in place to support that the intervention had been completed as set out in the plan of care.
Failure to ensure that the care provided to the resident as set out in their plan of care was documented may have diminished the level of accountability of the staff providing care.

Sources: Resident's care plan, documentation task survey report, and interview with staff [741074].

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 27 (2) 6.
24-hour admission care plan
s. 27 (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
6. Known health conditions, including allergies, adverse drug reactions and other conditions of which the licensee should be aware upon admission, including interventions.

The licensee has failed to ensure that the 24-hour admission care plan for a resident included, at a minimum, previously known health conditions.

Rationale and Summary

A resident was admitted to the home on a specified date. A review of preadmission paperwork indicated that the resident had a known history of two specified health conditions that were not specified in their 24-hour admission care plan nor their care plan to date. Within a month of being in the home, the resident was sent to hospital and returned on palliative measures from complications related to this health condition.

Failure to ensure that the 24-hour admission care plan and care plan to date

contained, at a minimum, the above known health conditions, put the resident at risk for infection.

Sources: Preadmission paperwork including medical report, health assessment and behavioural assessment, Critical Incident report, interviews with staff [000769].

WRITTEN NOTIFICATION: Responsive behaviours

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (a)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible

The licensee failed to ensure that the behavioural triggers for a resident's responsive behaviours were identified where possible.

Rationale and Summary

A resident had responsive behaviours. Staff identified two specific behavioural triggers for the resident that were not identified in the plan of care.

Failure to ensure these behavioural triggers were identified as known triggers for responsive behaviours of the resident put the resident at risk of not having their responsive behaviours managed.

Sources: Current plan of care for resident, Critical Incident report, interviews with

staff [000769].

WRITTEN NOTIFICATION: Infection prevention and control program

NC #007 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 failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, revised September 2023, was implemented.

A) Rationale and Summary

The IPAC Standard for Long-Term Care Homes indicated under section 10.4 that the licensee shall ensure that the hand hygiene program included: (h) Support for residents to perform hand hygiene prior to receiving meals and snacks, and after toileting.

On a specified date, Inspector #741074 observed a staff person ask several residents if they wanted an afternoon snack. The staff person provided each of these residents with a glass of juice and a cookie from the snack cart. None of these residents were supported with hand hygiene prior to receiving their snack, and were noted to be eating with their hands. The staff person indicated that they were unaware that support with hand hygiene was to be provided at snacks as well as

meals times.

In an interview with the IPAC Lead, they indicated that staff should be carrying the same disinfecting wipes used before meals or use alcohol-based hand rub available in the resident's rooms and hallway to support residents with hand hygiene prior to receiving their snacks. They indicated that this staff person came to them regarding the incident, and that they were re-trained on this.

Failure to support residents with hand hygiene prior to receiving their snack increased the risk of transmission of infectious agents.

Sources: Observations and interviews with staff. [741074]

B) Rationale and Summary

The IPAC Standard for Long-Term Care Homes indicated under section 9.1 that the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Additional Precautions shall include: (f) Additional personal protective equipment (PPE) requirements including appropriate selection application, removal and disposal.

On a specified date, a resident who was typically on routine contact precautions was placed on additional droplet precautions. A gown, gloves, N95 respirator and eye protection was required when providing care. Four staff were observed to provide care to the resident on this day. Three of the staff were observed not to be wearing an N95 respirator or eye protection while providing care, and one of the staff was observed not to be wearing an N95 respirator. All four staff indicated that they did not select the appropriate PPE because they did not realize the resident was on additional droplet precautions. Inspector noted that droplet contact

precaution signage was placed on the resident's door however, the old contact precaution signage had not been taken down.

Sources: Observations and interviews with staff [741074].