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: October 11, 2024

Inspection Number: 2024-1477-0002

Inspection Type:
Critical Incident

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

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

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: September 12-13, 16-20, 23-24, 2024.

The following intakes were inspected:

- Intake 00110317/ CI 3049-000021-24 & Intake 00110796/ CI 3049-000023-24 were related to prevention of abuse and neglect;
- Intake 00111141/ CI 3049-000024-24 & Intake 00116337/ CI 3049-000039-24 were related to injuries of unknown etiology;
- Intake 00114800/ CI 3049-000034-24 was related to the medication management system;
- Intake 00118974/ CI 3049-000047-24 was related to outbreak management; and
- Intake 00124029/ CI 3049-000057-24 was related to falls prevention and management.

The following intake was completed in this inspection:

- Intake 00115855/ CI 3049-000036-24 was related to falls prevention and management.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of Licensee to Comply with Plan

NC #001 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.

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 exhibited altered skin integrity when staff approached them for morning care. On the prior shift, the resident received care from one staff member when they required two-person assistance for care. Nursing management confirmed care was not provided as specified in the plan of care.

When the resident was not provided care as specified in their plan, there was risk to the resident's safety and health.

Sources: Resident's clinical record, interviews with staff.

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
2. The outcomes of the care set out in the plan of care.

The licensee failed to ensure the outcomes of the care set out in the plan of care for a resident were documented.

Rationale and Summary
Staff indicated that a resident demonstrated multiple responsive behaviours during care on a specified date. They documented that the resident did not demonstrate any behaviours. Nursing management acknowledged that staff were to document behaviours exhibited by residents.

Failure to document behaviours demonstrated by the resident resulted in the clinical record displaying an inaccurate description of the resident's interaction with staff during care.

Sources: Resident's clinical record, responsive behaviour program, interviews with staff.

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

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

Non-compliance with: FLTCA, 2021, s. 25 (1)

Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee failed to ensure that the long-term care home's (LTCH) written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary

Section two of the Ontario Regulation (O. Reg.) 246/22 and the LTCH's written abuse policy defined physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain. A critical incident system (CIS) report was submitted reporting an allegation of staff to resident physical abuse.

i) A staff member allegedly witnessed an incident of staff to resident abuse and did not report the incident for several days. The home's written abuse policy required staff to report their suspicion of abuse immediately to the senior administrative personnel. Nursing management acknowledged the alleged incident of abuse was not immediately reported to the appropriate staff.

ii) The staff member who allegedly witnessed the incident of staff to resident abuse notified another staff member, who did not immediately report the allegations to senior administrative personnel as required by the home's written abuse policy.

Failure for the staff to comply with the home's written abuse policy delayed the response to the alleged incident, including the home's investigation, assessments

and other measures to ensure the health and safety of the resident.

Sources: Resident's clinical record, LTCH investigation notes, CIS: 3049-000023-24, zero tolerance policy, interviews with staff.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (2) (a)
Responsive behaviours
s. 58 (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(a) integrated into the care that is provided to all residents;

The licensee failed to ensure that matters referred to in subsection (1) were integrated into the care that was provided to all residents.

Specifically, written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours and internal reporting protocols within the home's responsive behaviours program were not integrated into the care provided to multiple residents at the LTCH.

Rationale and Summary
A) A resident demonstrated multiple responsive behaviours during care. The staff continued providing care and did not notify registered nursing staff of the resident's behaviours. The home's responsive behaviour program required direct care staff to stop providing care, review the resident's plan of care and notify registered nursing staff of the behaviours before reattempting care. Nursing management acknowledged that the staff should have stopped performing care and reported to

registered nursing staff.

Failure to ensure the required approaches were integrated into the resident's care posed a risk of discomfort and distress during care.

Sources: Resident's clinical record, LTCH investigation notes, CIS 3049-000023-24, responsive behaviour program, interviews with staff.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (3) (a)
Responsive behaviours
s. 58 (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices;

The licensee failed to ensure that the matters referred to in subsection (1) were implemented for a resident.

Specifically, written approaches to care, including screening protocols, assessments and identification of behavioural triggers that may result in responsive behaviours and written strategies, including techniques and interventions, to prevent, minimize or respond to the identified behaviours, were not implemented for a resident.

Rationale and Summary
A resident had demonstrated multiple responsive behaviours toward staff during care for a specified period of time. The home's responsive behaviour program

required registered staff to screen and assess all residents for risk of responsive behaviours on admission through completion of a specified assessment. Nursing management acknowledged that the assessment had never been completed for the resident.

Failure to ensure the required approaches and strategies were implemented may have resulted in behavioural triggers and interventions not being communicated to staff or integrated into care provided to the resident.

Sources: Resident's clinical record, CIS 3049-000023-24, responsive behaviour program, interviews with staff.

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) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure actions were taken to respond to the needs of a resident, including assessments related to their responsive behaviours.

Rationale and Summary
A resident demonstrated multiple responsive behaviours toward staff during care and a referral to an external agency for an assessment was processed. At the time

of the inspection, an assessment by the agency had not yet been completed and nursing management acknowledged that the assessment had been missed.

Failure to ensure actions were taken to respond to the resident's behaviours may have led to behavioural triggers not being identified and strategies not trialed to support the resident's needs.

Sources: Resident's clinical record, CIS 3049-000023-24, interviews with staff.

WRITTEN NOTIFICATION: Administration of Drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A resident's clinical record provided direction to registered nursing staff to hold a medication when a particular biomarker was below a specified level. The resident was administered the medication when the biomarker was below the level specified in their plan of care, which led to the resident requiring additional medical intervention. Nursing management confirmed staff did not administer the medication in accordance with the directions for use outlined in the plan of care.

Failure to ensure that a drug was administered in accordance with the directions specified by the prescriber placed the resident at risk for medical complications.

Sources: Resident's clinical record, LTCH investigation notes, CIS 3049-000034-24, interview with staff.

COMPLIANCE ORDER CO #001 Transferring and Positioning Techniques

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1. Educate identified staff on a specified resident home area (RHA) on safe transferring practices, including where to identify a resident's transfer requirements, sling sizes and the steps to take to report an unsafe transfer. Maintain documentation of what education was provided and to whom, on what date, by whom and the signatures of staff in attendance.

Grounds
The licensee failed to ensure that staff used safe transferring techniques when assisting multiple residents.

Rationale and Summary
A) On a specified date, staff transferred a resident without a mechanical lift, which

they required as per their plan of care at the time of the transfer. Nursing management acknowledged this was an unsafe transfer.

When staff used an unsafe transferring technique, the resident was placed at risk of injury and discomfort during care.

Sources: Resident's clinical record, LTCH investigation records, interviews with staff.

B) On the same date, staff transferred another resident without a mechanical lift, which they required as per their plan of care at the time of the transfer. Nursing management acknowledged this was an unsafe transfer.

When staff used an unsafe transferring technique, the resident was placed at risk of injury and discomfort during care.

Sources: Resident's clinical record, LTCH investigation records, interview with staff.

This order must be complied with by December 2, 2024

COMPLIANCE ORDER CO #002 Infection Prevention and Control Program

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Educate a specified staff member on the LTCH's expectations for supporting residents with hand hygiene prior to meal service, including tray service. Maintain documentation of what education was provided, on what date, by whom and the staff's signature.
2. Audit the staff's resident mealtime hand hygiene practices, including tray service, on a specified RHA across three shifts or until compliance is achieved. Maintain documentation of the audits, names of staff who completed each audit, outcomes and any corrective action taken based on audit results.

Grounds

The licensee failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes was implemented.

Rationale and Summary

The IPAC Standard required under section 10.2 that the hand hygiene program was to include hand hygiene support for residents, specifically (c) assistance to residents to perform hand hygiene before meals.

During an observation of meal service on a specified RHA, a staff member delivered lunch trays to multiple residents in their rooms and did not support the residents with cleaning their hands before their meal. The residents did not have access to hand hygiene agents within reach from where they were served their tray. Two of the residents confirmed they were not offered hand hygiene prior to eating their lunch. One resident had additional precautions in place at the time of the observation.

The home's hand hygiene program required staff to use the appropriate ABHR

located in dining spaces and resident areas to support the cleaning of residents' hands before meals. LTCH management acknowledged that staff were expected to support residents with hand hygiene prior to their meal, including the provision of hand hygiene to residents at tray service using ABHR wipes.

Failure for staff to support residents with hand hygiene prior to meal service posed a risk of infectious disease transmission.

Sources: Meal service observation, IPAC Standard (revised September 2023), hand hygiene program, interviews with staff.

This order must be complied with by November 22, 2024

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

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.