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: January 16, 2024	
Inspection Number: 2023-1550-0003	
Inspection Type: Proactive Compliance Inspection	
Licensee: The Regional Municipality of Niagara	
Long Term Care Home and City: Gilmore Lodge, Fort Erie	
Lead Inspector Nishy Francis (740873)	**Inspector Digital Signature** Nishy Francis Digitally signed by Nishy Francis Date: 2024.01.17 14:14:46 -05'00'
Additional Inspector(s) Jonathan Conti (740882)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 11, 12, 14, 18 - 21, 2023
The inspection occurred offsite on the following date(s): December 15, 2023

The following intake(s) were inspected:

- Intake: #00103519 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration

Medication Management
Residents' and Family Councils
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee failed to ensure that a residents plan of care was revised when the resident's care needs changed for level of assistance required for personal hygiene.

Rationale and Summary
The resident's plan of care indicated that the resident required a level of assistance for personal care. The care plan review from inspector 740882 indicated the same.

Documentation entered by staff for a period of time, however, indicated that the resident was not receiving the level of assistance as required in the care plan.

Staff stated that the resident was able to help with certain tasks of personal hygiene and required further assistance with other tasks. The resident confirmed the same.

The Clinical Documentation and Informatics Lead (CDI Lead) reassessed with staff and the resident and revised the level of assistance required for personal hygiene.

As of a specified date, the resident's plan of care indicated the correct level of assistance required for personal hygiene.

Sources: resident clinical record including care plan, progress notes; interview with staff and CDI Lead. [740882]

Date Remedy Implemented: December 20, 2023

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20 (a) can be easily seen, accessed and used by residents, staff and visitors at all times;

The licensee failed to ensure that the home's equipped resident-staff

communication and response system (RSCRS) that could easily used by residents, staff and visitors at all times.

Rationale and Summary

On a specified date, the call bell at the bed side for a resident's room was tested by inspector #740882 and a staff. The call bell button was not noted to be on the device, and when the inspector attempted to press to use, the call bell did not activate. The resident had an intervention in their plan of care to ensure the call bell is within easy reach and was encouraged and reminded to call for assistance.

The staff reported to another staff, who also tested and confirmed the call bell could not be used. The staff returned to the room and replaced the call bell cord with a bell that had the red button present and was connected to the RSCRS. The Director of Resident Care (DRC) acknowledged that by the call bell cord not functioning, the RSCRS would not be useable for the resident, visitor, or staff. The DRC confirmed the call bell was replaced right away when brought forward from staff.

As of a specified date, the malfunctioning call bell was replaced by registered staff, and was in working order. Follow-up with the DRC confirmed that the new call bell was in place.

There was no impact or risk to the resident at time of non-compliance due to the replacement of the cord prior to the resident returned to the room.

Sources: observation of room; interviews with staff; resident clinical record. [740882]

Date Remedy Implemented: December 12, 2023

WRITTEN NOTIFICATION: Dining and Snack Service

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

Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.

Dining and snack service

s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure that residents in the a Resident Home Area were served food and fluids at temperatures which were palatable to the residents.

Rationale and Summary

Prior to serving lunch to residents in a Resident Home Area, the temperature of food being served was not recorded. A dietary aide staff confirmed food temperatures were not recorded prior to the meal service. The Nutrition Manager verified that prior to a meal service, food temperatures were to be recorded to ensure safe food holding temperatures have been maintained. The home's policy titled Temperature Recording stated food temperatures were to be monitored and recorded prior to a meal service.

When the home failed to record food temperatures prior to a meal service, there is a risk that safe food handling temperatures have not been maintained.

Sources: Interview with Dietary Aide staff and the Nutrition Manager; Record review of the home's manual titled Dietary, Recreation, Rehabilitation and Volunteers, procedure titled Food Temperature, last revised May 11, 2022, and review of Food Temperature Record for December 11, 2023. [740873]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 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 additional precautions for a droplet and contact precaution room were followed regarding the appropriate selection of Personal Protective Equipment (PPE) upon entering the room, in accordance with the "Infection Control (IPAC) Standards for Long Term Care Homes, under section 9.1 (f), April 2022, revised September 2023" (IPAC Standard).

Rationale and Summary
A resident home area was under COVID-19 outbreak precautions. An identified resident's room had signage that required the use of an N95 respirator along with droplet and contact precautions in addition to routine practices.

On a specified date, a staff was observed entering the identified resident's room on the RHA. Outside of the resident's room was a PPE cart where the staff selected PPE from, and N95 masks were available for selection. Signage on the door required additional droplet and contact precautions with PPE including an N95 mask, gloves, gown, and eye protection.

The staff selected and donned a procedural mask with eye protection, gloves, and a gown. The staff delivered the residents lunchtime meal on a tray and interacted with

the resident during set up.

The staff, DRC, and the IPAC Program Manager confirmed N95 mask usage was required when entering and interacting or caring for residents in a droplet/contact precautions room. The staff acknowledged they did not don the appropriate PPE as required.

There was a potential risk for spread of infection when the staff member used incorrect PPE during resident interaction in additional precautions room.

Sources: observations; staff, DRC, and IPAC program manager interviews; resident clinical record and signage on door. [740882]