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

North District
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Original Public Report

Report Issue Date: February 24, 2023	
Inspection Number: 2023-1206-0003	
Inspection Type: Proactive Compliance Inspection (PCI)	
Licensee: The District of the Municipality of Muskoka	
Long Term Care Home and City: Fairvern, Huntsville	
Lead Inspector Chad Camps (609)	**Inspector Digital Signature** Chad A Camps Digitally signed by Chad A Camps Date: 2023.03.14 15:07:01 -04'00'
Additional Inspector(s) Amy Geauvreau (642)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): January 9-13, 16-20, 2023.

One Proactive Compliance Inspection (PCI) Intake was inspected.

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
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Training

Non-Compliance (NC) #001 Written Notification pursuant to Fixing Long-Term Care Act, 2021, Section (s). 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 9.

The licensee has failed to ensure that a staff member completed their infection prevention and control training, before performing their duties.

Rationale and Summary

A staff member stated that they had not completed their infection prevention and control training before performing their duties.

The Infection Prevention and Control (IPAC) Lead verified that the staff member had not completed their required IPAC training.

The home's failure to ensure that the staff member completed IPAC training presented moderate risk to residents.

Sources: Staff training policy for IPAC; Online IPAC training records; Interviews with the IPAC Lead; and other staff. [642]

WRITTEN NOTIFICATION: Training

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (7) 1.

The licensee has failed to ensure that a staff member, who provided direct care to residents received, as a condition of continued contact with residents, training in abuse recognition and prevention.

Rationale and Summary

Pursuant to Ontario Regulation (O. Reg). 246/22 s. 261, the home was required to provide all direct care staff with annual training in abuse recognition and prevention.

A staff member denied completing abuse recognition and prevention training during 2022.

Despite the home's policy that required yearly training of staff on abuse recognition and prevention, the Director of Care (DOC) verified that the staff member last completed abuse training several years previously.

The home's failure to ensure that the staff member completed annual abuse training presented moderate risk to residents cared for by a staff member without up-to-date training in abuse recognition and prevention.

Sources: The home's policy titled "Prevention and Zero Tolerance of Resident Abuse & Neglect"; Hand-written note provided by the DOC; Interviews with the DOC; and other staff. [609]

WRITTEN NOTIFICATION: Training

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (7) 6.

The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in other areas provided for in the regulations.

Rationale and Summary

Pursuant to O. Reg. 246/22 s. 261, the home was required to provide all direct care staff annual training in falls prevention/management, skin and wound care and pain management.

a) A registered staff member denied completing any training in falls prevention and management during the 2022 year. The DOC verified that the staff member last completed falls prevention and management training several years previously.

b) A registered staff member denied completing any training in skin and wound care during the 2022 year. The DOC was unable to produce any record that the staff member completed skin and wound care education in 2022, or any other year.

c) A registered staff member could not recall completing any pain management training during the 2022 year. The Resident Care Manager described how during the COVID-19 pandemic

training had ceased and pain management training was not provided to staff in 2022.

The DOC verified that annual training of staff should have occurred in 2022.

The home's failure to ensure that staff completed annual training presented moderate risk of harm to residents cared for by staff without up-to-date training in falls, skin/wound and pain management.

Sources: The home's policies titled "Training and Orientation" and "Pain and Symptom Management"; Hand-written training record provided by the DOC; Interviews with the Resident Care Manager; the DOC; and other staff. [609]

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 (8)

The licensee has failed to ensure that staff members participated in the implementation of the IPAC program.

Rationale and Summary

Pursuant to the FLTCA, 2021, s. 23 (2) (e) the home is required to have a hand hygiene (HH) program as part of the home's IPAC program.

The home's HH program indicated that staff were to perform HH after body fluid exposure risk.

a) A staff member removed and reapplied their surgical mask without performing HH afterwards.

The staff member and the DOC verified that the staff member should have performed HH after repositioning their mask.

b) After removing their gloves after body fluid risk exposure, a staff member did not perform HH before they sat down in the nursing station.

The staff member and the DOC verified that the staff member should have performed HH after body fluid exposure risk.

The home's failure to ensure that the staff members performed HH after potential exposure to body fluids, presented moderate risk to residents, due to the possibility of disease transmission.

Sources: Observations of staff; The home's policy titled "Hand Hygiene Program"; Interviews with the DOC; and other staff. [609]

WRITTEN NOTIFICATION: Quarterly Evaluation

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 124 (1)

The licensee has failed to ensure that the interdisciplinary team, which included the Medical Director, the Administrator, the DOC and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Rationale and Summary

The last time the home's medication management system was evaluated by the interdisciplinary team was nearly two years ago.

The home's policy required the interdisciplinary team met quarterly, but the DOC described how COVID-19 had stretched the resources of the home which resulted in the interdisciplinary team not meeting.

The home's failure to ensure that the interdisciplinary team met to quarterly evaluate the medication management system presented low risk to residents as the pharmacist was evaluating the medication management system and sending monthly reports to the home.

Sources: The home's policy titled "Professional Advisory Committee (PAC)- Terms of Reference"; Fairvern Management Committee Meeting (aka PAC meetings) minutes; Interviews with the Pharmacist; and DOC. [609]

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 138 (1) (b)

The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in a locked area.

Rationale and Summary

The Inspector found controlled substances stored in a single-locked cupboard and/or box in a locked medication room.

Registered staff verified that a single-locked cupboard and/or box were used by staff to secure the controlled substances.

The DOC verified that controlled substances in the home were to be triple-locked.

The home's failure to triple-lock stored controlled substances presented no risk to residents.

Sources: Observations of a medication room; The home's policy titled "Medication – Storage of Controlled Substances"; Interviews with the DOC; and other staff. [609]

WRITTEN NOTIFICATION: Training and Orientation Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 257 (1)

The licensee has failed to ensure that the home's training and orientation program was implemented.

Rationale and Summary

An agency staff member was unable to recall if they received training on the home's abuse, fire or evacuation policies before they began working with residents.

The DOC and Administrator were unable to produce the agency staff member's training records, despite the home's policy which required written records be maintained of staff participation in the training and orientation program.

The home was unable to produce any written records of staff participation in the training and orientation program for staff from any of the agencies that provided the home with additional staff.

The Administrator acknowledged they needed to be aware of what training the agencies were providing before their staff began working with the home's residents.

The home's failure to maintain written records of agency staff training presented moderate risk of harm to residents cared for by agency staff who may not have had the required training.

Sources: The home's policy titled "Training and Orientation"; Interviews with the DOC; Administrator; and other staff. [609]

WRITTEN NOTIFICATION: Designated Lead

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 258

The licensee has failed to ensure that there was a designated lead for the training and orientation program.

Rationale and Summary

The DOC described how the home had no designated lead for the training and orientation program, while the home's policy indicated that the Administrator was the designated lead.

However, the Administrator stated they were unaware that the policy identified them as the designated lead for the training and orientation program.

The home's failure to ensure that there was a designated lead for the training and orientation program presented moderate risk of harm to residents cared for by staff without required and/or up-to-date training.

Sources: The home's policy titled "Training and Orientation"; Interviews with the DOC; and Administrator. [609]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 79 (1) 9.

The licensee has failed to ensure that a staff member used proper techniques when assisting residents to eat.

Rationale and Summary

A staff member stood at the table above two residents as they assisted them to eat.

The staff member stated that they were in a hurry when they stood to assist the residents to eat but knew they should have sat down.

The Dietitian and Support Services Manager verified that staff should sit when they assisted residents to eat which minimized the risk of difficulty swallowing and choking.

The staff member who stood up to assist residents with eating presented moderate risk of swallowing difficulties and/or choking to both residents.

Sources: Observations of a meal service; The home's policy titled "Meal Service – Dining Rooms"; Resident plans of care; Interviews with the Support Services Manager; Dietitian; and other staff. [609]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 72 (2) (a)

The licensee has failed to implement the home's policies and procedures related to nutritional care and dietary services.

Rationale and Summary

a) To reduce the risk of unsafe food storage conditions, fridge and freezer temperatures in the main kitchen were to be recorded three times per day.
During a nine-day review period, eight out of the nine days or 89 per cent of the days had missing freezer and/or fridge temperature recordings in the kitchen.

Dietary staff and the Support Services Manager acknowledged the missing temperature recordings.

Dietary staff stated that the process needed to "get better", while the Support Services Manager described how dinner time temperature recordings were frequently missed.

The Dietitian stated that the missing freezer and/or fridge temperature recordings were "unacceptable" but indicated that the risk to residents was low.

b) To reduce the risk of serving improperly handled foods, food temperatures were to be checked and recorded at the point of service for breakfast, lunch, and supper.

On one day of the review period, two foods were served to residents before a temperature check of the foods was recorded.

The Support Services Manager verified that Dietary staff should have recorded the temperatures of the two foods before they were served to residents.

Dietary staff's failure to record the temperatures of the two foods presented low risk to residents.

Sources: The home's policy titled "Temperature Monitoring of Freezers and Refrigerators"; The Cold Food Holding Temperature Surveillance Sheet; The home's policy titled "Temperature Monitoring of Food"; The kitchen Pandemic Fall/Winter 2022-2023 Production sheet; Interviews with the Support Services Manager; Dietitian; and other staff.