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

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Original Public Report

Report Issue Date: January 22, 2024	
Inspection Number: 2023-1318-0005	
Inspection Type: Complaint Critical Incident	
Licensee: Regency LTC Operating Limited Partnership, by it general partners, Regency Operator GP Inc. and AgeCare Iris Management Ltd.	
Long Term Care Home and City: AgeCare Wenleigh, Mississauga	
Lead Inspector Patrishya Allis (000762)	**Inspector Digital Signature** Patrishya Allis Digitally signed by Patrishya Allis Date: 2024.01.26 09:49:54 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 1, 5-8, 11-12, 14-15, 18-22, 2023

The following intake(s) were inspected:

- Intake: #00099569 - CI related to COVID-19 outbreak
- Intake: #00101592 - Complaint regarding medication management, food, nutrition and hydration, and prevention of abuse and neglect

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

Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medication management system

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 123 (2) Medication management system

s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee has failed to ensure that a written policy for the medication management system was complied with.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure any plan, policy, protocol, program, procedure, strategy, initiative, or system is complied with. Specifically, staff did not comply with AgeCare Wenleigh policy titled "Automated Dispensing Cabinets", last revised June 2023, which outlined the emergency procedure to override to obtain access to the stat box.

Rationale and Summary

On a date in 2023, a resident's family member was concerned that the resident was uncomfortable and requested an assessment for a narcotic medication.

A Nurse Practitioner (NP) assessed the resident the next day, and indicated resident was showing signs of discomfort, including facial grimacing, and moaning. A narcotic subcutaneous as needed (PRN) was ordered for pain.

A Registered Practical Nurse (RPN), who was working with the resident confirmed

the resident was uncomfortable, and reported if the narcotic was available, they would have administered to promote comfort.

Once the order for the narcotic was available, RPN confirmed they could not obtain access to the narcotic stored in the stat box. This was because they did not have a password for the stat box, and after liaising with another RPN and a Registered Nurse (RN), it appeared the RN's passcode for the stat box was non-functional.

The RPN confirmed there was a total of six registered staff working that shift. One registered staff was from agency and the remaining were registered staff employed by the home. Another RN confirmed they had a password to access the stat box but were not informed by any staff that there was a need to access the stat box for a required medication.

No further troubleshooting was executed to obtain the medication from the stat box; RPN confirmed the order was provided to the evening nurse, who successfully administered the narcotic during their shift.

The Assistant Director of Care (ADOC) and Director of Care (DOC) confirmed all casual, part time, and full-time registered staff should have a password to access the stat box. Two passwords are required to obtain a narcotic (one to open the stat box, the second to witness the withdrawal of the narcotic). If the passwords are non-functional, a registered staff can request another nurse to access the stat box or follow the procedure to override access to the stat box, which is outlined in the home's policy titled: "Automated Dispensing Cabinets", last revised June 2023. ADOC confirmed all staff are expected to know the override policy and were provided with training upon the initiation of the stat box.

Failure to implement the override policy to obtain a required medication from the stat box resulted in a delay of treatment to control pain and discomfort for the

resident.

Sources: Review of Medication Administration Record (MAR), Automated Dispensing Cabinets Policy, Documentation Survey Report, interviews with staff.

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WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b) Plan of care: Integration of assessments, 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 has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and are consistent with and complement each other.

Rationale and Summary
A resident returned to the Long Term Care Home (LTCH) from hospital, on a date in 2023, with a diet texture and fluid consistency downgrade.

The resident passed away days after their return to the home.

The DOC reported the nurse in the resident home area is responsible for updating a resident's diet order in Point Click Care (PCC) under 'orders' and 'care plan' when the Registered Dietitian (RD) is not present in the LTCH.

Resident's diet order was updated in PCC the day after their passing, and the care plan was updated days after readmission. Resident's profile in Synergy showed no diet change was made up to time of death.

The Assistant Food Service Manager (AFSM) and RD were responsible for updating diet changes in Synergy, and the diet books located in each dining room; however, both staff were not present in the LTCH from the time of resident's return from hospital until the time of death. In their absence, the Food Service Manager (FSM) was responsible for updating Synergy and the diet books. The FSM confirmed they were not informed of the diet change and did not make any diet changes for the resident. Furthermore, a dietary referral was made upon resident's return from hospital, which indicated resident returned to the LTCH and there was a diet change. The FSM confirmed they did not review the referral.

Review of the nursing communication book did not indicate any changes were made to the resident's diet upon return from hospital. The only form of communication related to resident's diet change was an order in the resident's chart that indicated "follow Speech and Language Pathologist (SLP) recommendations from hospital".

A Dietary aide (DA) and Personal Support Worker (PSW) confirmed the dietary aide's prepare resident meals based on the diet texture indicated in the diet book. PSW confirmed nurses do not review and verify accurate meal textures are provided to residents.

The resident was fed breakfast by staff two days after their return to the LTCH. Resident was noted to be coughing, was congested, and could not swallow. Family noticed congestion and coughing later that day.

The licensee did not ensure the diet order provided to the resident was consistent with the prescribed diet order in hospital, this jeopardized the swallowing safety to the resident as the wrong diet texture could have been provided.

Sources: Record review of resident's diet order and care plan in PCC, Synergy diet report history, progress notes, interviews with staff.

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WRITTEN NOTIFICATION: Duty to protect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1) Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect a resident from neglect.

Rationale and Summary
A resident completed a course of therapy for an infection on a date in 2023. Later that month, the resident's family member requested a diagnostic test to be ordered due to their suspicion that the resident had not recovered from the previous infection, as their symptoms did not improve. The DOC confirmed the results of the diagnostic test were provided to the LTCH several days after the service date.

Interview with Registered Practical Nurse (RPN) and Personal Support Worker (PSW) confirmed resident did not return to baseline and there was no improvement after treatment was completed. RPN could not recall if they reported symptoms to the medical doctor or nurse practitioner, and PSW stated they reported symptoms to a nurse but could not recall the name.

A review of the progress notes, written by the Medical Doctor (MD), Nurse Practitioner (NP), and registered staff, after the course of treatment was completed, showed no concerns related to the resident.

During an interview with Nurse Practitioner (NP), they reviewed the results of the diagnostic test, and confirmed the results were positive for an infection. The NP

denied reviewing the results or being informed of the results previously. NP further noted the only time they were informed that the resident was unwell was on the day they were transferred to hospital, when the DOC informed NP that a family member shared concerns about resident being lethargic.

The DOC confirmed it was the expectation for staff to review the result of a diagnostic test and report abnormal results after-hours to the on-call doctor same day, or directly to the NP or MD if present. If the nurse contacted the MD or NP, they would be expected to document this in the twenty-four-hour report book or write a progress note. The MD or NP would also write a progress note to indicate the abnormal results were addressed.

Upon review of progress notes and the nursing communication book, there was no documentation to suggest the results of the diagnostic test were reviewed or communicated to the MD or NP.

The resident was transferred to hospital as per son's request. In hospital, the son was informed that the resident had an infection and received medical treatment.

Failure to report lack of symptom improvement and results of the diagnostic test to the MD/NP contributed to a delay in assessment and treatment, which placed the resident at risk of prolonged pain and discomfort.

Sources: Review of hospital assessment note, progress notes, medical orders, diagnostic test results, twenty-four-hour communication book, interviews with staff.

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WRITTEN NOTIFICATION: ADMINISTRATION, MISCELLANEOUS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3) Directives by Minister: Binding on licensees

s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every operational or policy directive that applies to the long-term care home, the policy was complied with.

In accordance with the Minister's Directive: COVID-19 Response Measures for Long-Term Care Homes in Ontario, the licensee was required to ensure enhanced environmental cleaning and disinfection for frequently touched surfaces was performed.

Rationale and Summary
The home was declared to be in a COVID-19 outbreak on October 16, 2023. The outbreak ended on November 13, 2023.

The document from Public Health Ontario titled, "Key Elements of Environmental Cleaning in Healthcare Settings" last updated July 16, 2021, identified that frequently touched surfaces such as doorknobs, call bells, bedrails, light switches, toilet handles, handrails, and keypads were to be cleaned and disinfected at least once per day and more frequently in outbreak areas.

A housekeeper stated there was one housekeeping shift daily in each home area, and resident room cleaning was performed every other day when the LTCH was not in outbreak. The Environmental Services Manager (ESM) confirmed it was the expectation that resident rooms are to be cleaned daily when not in outbreak.

A review of the high touch surface cleaning tracker sheets was completed for identified time periods in some areas of the home. The infection Prevention and Control audits indicated the tracker sheets were missing on two identified dates for specific areas of the home. The IPAC lead, confirmed they did not receive the housekeeping high touch cleaning records.

The housekeeper confirmed resident room high touch surface cleaning was not performed daily when the home was not in outbreak.

When enhanced cleaning did not occur, the prevention of outbreak and safety to residents was jeopardized.

Sources: Record review of high touch surface cleaning tracker sheets, IPAC audits, AgeCare Long Term Care Policy titled "02-Infection Prevention: Cleaning, Disinfection and Sterilization", Key Elements of Environmental Cleaning in Healthcare Settings, interviews with staff.

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WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i) Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure a resident, who was exhibiting altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Rationale and Summary

Review of the Documentation Survey Report showed a resident had skin impairments on a date in 2023, which was documented by a PSW.

The PSW confirmed the skin impairments were present and responded to this by applying a treatment cream on the affected area, documenting in Point of Care (POC), and reporting to the nurse; the name of the nurse could not be recalled.

During an interview with another PSW, who provided care to the resident, reported they also noticed altered skin integrity. PSW reported to agency nurse and was told to apply a cream.

The wound care nurse reported upon identification of a new wound, registered staff are to complete an initial skin assessment, and inform the skin and wound nurse.

The wound care nurse confirmed they were not informed of resident's skin breakdown prior to their date of hospital admission. They further reported that agency staff do not always complete the skin assessments as required, and the progression of such a wound takes place in a 'matter of days'.

The resident was admitted to hospital days later. The weekly skin and wound assessment form was completed on the day of hospital admission, which showed there were several wounds.

Failure to complete an initial skin and wound assessment upon a new onset of altered skin integrity hindered the timely assessment and treatment, which placed the resident at risk for the progression of wounds.

Sources: Review of Documentation Survey Report, progress notes, hospital notes, AgeCare Skin Care Program Overview Policy, Skin and wound assessment forms, interviews with staff.

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WRITTEN NOTIFICATION: Pain management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 57 (2) Pain management

s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary:

A comprehensive pain assessment was completed upon resident's return to Age Care Wenleigh LTCH on a date in 2023, which indicated resident had no pain, and interventions indicated for pain control included an analgesic.

Days later, resident's pain was documented in progress notes on multiple days and a new analgesic drug order was provided for pain management.

Review of all assessments showed no clinically appropriate pain assessment form was completed despite a new onset of pain that was not relieved by the initial intervention.

The Resident Assessment Instrument (RAI) Coordinator confirmed a comprehensive pain assessment should have been completed, and no assessment form was completed.

Failing to complete a comprehensive pain assessment after new onset of pain hinders the determination of pain characteristics and timely treatment.

Sources: Interview with RAI Coordinator, review of Comprehensive pain assessment form, progress notes, resident's chart

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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 has failed to ensure that where the Regulation required the licensee of a long-term care home to carry out every standard or protocol issued by the Director with respect to infection prevention and control, the Director's issuance was complied with.

In accordance with the Infection Prevention and Control (IPAC) Standard for long-term care homes, Standard 10.4 h, the licensee was required to ensure that the hand hygiene program included support for residents to perform hand hygiene prior to receiving meals and snacks.

Rationale and Summary

The home's titled, "Hand Hygiene Program" last revised September 2022, identified that hand hygiene is to be performed before eating food. The IPAC Lead confirmed hand hygiene should be completed for all residents before and after meals.

During lunch observations of a dining room on a date in 2023, staff did not assist residents with hand hygiene before and after eating. This was confirmed with three residents, who reported staff do not assist with cleaning hands before and after eating meals.

Failure to assist residents with performing hand hygiene before and after eating places them at risk for being exposed to infectious disease and increases their likelihood of transmitting viruses.

Sources: Interview with IPAC Lead, interview with residents, observations of a dining room, AgeCare Wenleigh Policy titled "Hand Hygiene Program".

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WRITTEN NOTIFICATION: Infection prevention and control program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (7) 11. Infection prevention and control program

s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:

11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

The licensee has failed to ensure that there was access to hand hygiene agents at point of care.

Rationale and Summary

On a date in 2023, observations of three dining rooms within Age Care Wenleigh LTCH was conducted. In the first dining room, inspector did not observe wet wipes filled in the dispenser inside the dining room, which was confirmed by a PSW.

In the second dining room, inspector did not observe wet wipes filled in the dispenser, or portable hand sanitizer available inside the dining room to be used at point of care.

In the third dining room, inspector did not observe hand sanitizer inside the dining room to be used at point of care, which was confirmed by a Dietary Aide.

During an interview with the IPAC Lead, they reported hand hygiene should be completed for all residents before and after meals, and a portable alcohol-based hand rub (ABHR) should be readily available in the dining room because the ABHR dispenser located outside of the dining room may be hard to reach for some residents. Wet wipes should also be available in the dining room for cleaning hands.

By not providing an alcohol-based hand rub at point of care, residents within the Long Term Care Home were placed at low risk for being exposed to infectious disease as lack of access to hand sanitizer may decrease the number of times they are able to disinfect their hands to reduce the likelihood of transmitting viruses.

Sources: Observations of the dining rooms, interviews with staff.

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