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 July 6, 2022
Inspection Number 2022_1272_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Collingwood Nursing Home Limited

Long-Term Care Home and City
Collingwood Nursing Home, Collingwood

Lead Inspector
Daniela Lupu (758)

Inspector Digital Signature
Daniela Lupu Digitally signed by Daniela Lupu
Date: 2022.07.15 18:27:14 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 25-27, 30-31, June 1-3 and 6-8, 2022.

The following intake(s) were completed in this Complaint inspection:

- Log # 006049-22 (Complaint) related to allegations of abuse and neglect.

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

- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Reporting and Complaints
- Safe and Secure Home
- Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

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

Non-compliance with: LTCHA, 2007 *s*. 6(5)

The licensee has failed to ensure that a resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care related to skin and wound care.

Rationale and Summary

A resident had an area of skin concern and their plan of care included specific directions for dressing changes and wound care.

The frequency of dressing changes was reduced twice in a one-week period and in approximately one month, the area changed in condition.

The resident's substitute decision maker was not notified of these changes.

The Director of Care (DOC), and the Assistant Director of Care (ADOC) said the resident's substitute decision maker should have been notified of the above changes.

By not informing the resident's substitute decision maker about the changes in condition of the wound site and the frequency of the dressing changes, the resident's substitute decision maker was not fully involved in the development and implementation of the resident's plan of care related to skin and wound care.

Sources: a resident's clinical records, the home's investigative notes, and interviews with an RPN, the ADOC and the DOC.
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WRITTEN NOTIFICATION: SKIN AND WOUND CARE

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 79/10, s. 50 (2) (b) (ii)

The licensee has failed to ensure a resident received immediate treatment and interventions to promote healing for their area of skin concern.

Rationale and Summary

A resident had an area of skin concern and had specific directions for dressing changes and treatment.

The frequency of dressing changes was reduced, and in approximately one month, the condition of the affected area worsened.

On one occasion, the treatment was not applied as prescribed. On multiple occasions, the treatment applied was not effective and the skin area did not improve.

On three separate occasions, the treatment applied was ineffective and the area deteriorated. No immediate interventions to promote healing were implemented on the above occasions when the area continued to deteriorate.

Despite the home's wound care protocols, there was no record that the physician, the nurse practitioner (NP) or enterostomal therapy (ET) nurse were informed or consulted in relation to the deterioration of the resident's area of skin concern.

The treatment and frequency of dressing changes for the area were not changed until after the discussion with the resident's substitute decision maker one month later.

The home's Wound Care Nurse and the DOC said that the NP should have been consulted when the treatment was not effective, and the condition of the area worsened.

These gaps in implementing immediate interventions to promote healing of the resident's area of skin concern when it started to deteriorate had a moderate impact on the resident.

Sources: a resident's progress notes, wound assessments, physician's orders, electronic treatment administration record (eTAR), electronic medication administration record (eMAR), digital wound pictures**,** the home's skin and wound policy and interviews with the home's Wound Care Nurse, a RPN, DOC, and other staff.
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WRITTEN NOTIFICATION: SKIN AND WOUND CARE

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

Non-compliance with: O. Reg. 79/10 s. 50 (2) (b) (iv)

The licensee has failed to ensure that a resident's area of skin concern was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

A resident had an area of skin concern prior to their admission to the home. The resident's area of skin concern was to be assessed weekly by the registered staff.

There were no weekly skin assessments completed for one month. On two separate occasions, the weekly wound assessments were not completed, and on one of these occasions, the condition of the skin worsened.

Gaps in the weekly wound assessments contributed to the worsening condition of the area of skin concern.

Sources: a resident's wound assessments, progress notes, eTAR, eMAR, and interviews with a RPN, ADOC and DOC.
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WRITTEN NOTIFICATION: DINING AND SNACK SERVICE

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: s. 73(1)6 under O. Reg. 79/10 and s. 79(1)5 under O. Reg. 246/22

The licensee has failed to ensure that their dining and snack service included elements to ensure food and fluids were served at a temperature that was safe for the residents.

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA. As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 73(1)6 of O. Reg. 79/10. Non-compliance with the applicable requirement also occurred after April 11, 2022, which falls under s. 79 (1)5 of O. Reg. 246/22.

Rationale and Summary

The home's policy related to food temperatures, documented that point of service temperatures for all menu items should be checked and recorded by the Dietary Aides at a specific time prior to the commencement of meal service.

The home's dietary service provider's policy documented that the temperatures of hot potentially hazardous food should be checked at specific time intervals and these temperatures should be recorded. Additionally, the temperatures of hot potentially hazardous food should be checked when foods are removed from any hot holding equipment or brought from the kitchen for holding, display or service.

A. Non-compliance with s. 73(1)6 under O. Reg. 79/10

On one occasion, during the lunch meal service, a resident spilled their hot food item and sustained an injury which needed specific treatment.

On the same occasion, the home's temperature log records, did not include records for the hot food items holding or the point of service temperatures.

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

Observations of the lunch meal service on three separate occasions showed that Dietary Aides did not check the food and hot beverage temperatures at the point of service.
In a three-month period, the home's temperature log records showed that the point of service temperatures were not recorded.

The home's cook said that they did not check the food temperatures at the required frequency. Two Dietary Aides said they did not check any food temperatures on holding or at the point of service.

The home's Food Service Supervisor and the DOC said that food temperatures should be checked and recorded as per the home's dietary policies.

Staff not checking the food temperatures at the point of service and at the frequency indicated in the home's policies had a moderate impact on a resident and posed a potential risk of harm for all residents.

Sources: observations of the meal service**,** a resident's progress notes and assessments, the home's food temperature log records, the home's dietary policies, and interviews with a cook, two Dietary Aides, the home's Food Service Supervisor and the DOC.
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WRITTEN NOTIFICATION: COMPLIANCE WITH MANUFACTURERS' INSTRUCTIONS

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

Non-compliance with: O. Reg. 79/10, s. 23

The licensee has failed to ensure that staff used a resident's wheelchair in accordance with the manufacturer's instructions.

Rationale and Summary

A resident had mobility limitations and was at risk for falls. The resident needed to use a wheelchair for locomotion and transfers.

The manufacturer's instructions for the resident's wheelchair documented that at every use a safety check list should be completed to ensure the wheelchair is used properly.

On one occasion, one of the safety features of a resident's wheelchair broke. The wheelchair was not repaired until a week later.

The resident continued to use their wheelchair for transfers when the safety feature was broken, despite manufacturer's instructions indicating that the safety features were needed for transfers from and to the wheelchair.

The home's physiotherapist and the former occupational therapist (OT) said that using the resident 's wheelchair without the safety feature was not safe.

There was potential risk of harm to the resident when staff did not follow the manufacturer's instructions related to the proper use of the wheelchair during the transfers as it could cause the resident to fall and become injured.

Sources: a resident's care plan, the home's repairs log for assistive devices, the owner's manual for a resident's wheelchair, and interviews with two PSWs, a RN, the physiotherapist, the OT, and the DOC.
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WRITTEN NOTIFICATION: NOTIFICATION RE: PERSONAL BELONGINGS

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

Non-compliance with: O. Reg. 79/10 s. 38 (a)

The licensee has failed to ensure that a resident's substitute decision-maker was notified when the resident's wheelchair was not in good working order or required repair.

Rationale and Summary

A safety feature of a resident's wheelchair broke and needed to be replaced.

The resident's substitute decision maker was not notified. Four days later, they discovered that the resident's wheelchair needed repair.

A RPN and the DOC said the resident's substitute decision maker should have been immediately notified when the resident's wheelchair required repair or did not work properly.

Not notifying the resident's substitute decision maker prevented them from advocating for the resident to receive timely repairs for their wheelchair.

Sources: a resident's progress notes, the home's repairs log for assistive devices, and interviews with a RPN and the DOC.
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WRITTEN NOTIFICATION: MAINTENANCE SERVICES

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 96(2)(b)

The licensee has failed to ensure that procedures were developed and implemented to ensure that facility wheelchairs were kept in good repair.

Rationale and Summary

During an interview with a RN, they said that there were no preventative maintenance or safety checks completed to ensure the home's regular and transport wheelchairs and walkers were kept in good repair. They also said that a process was not established with the home's service provider.

The home's assistive devices repair log did not include any preventative maintenance for the home's assistive devices.

By not ensuring that the home's assistive devices were maintained in good repair there was a potential risk of injury to the residents.

Sources: the home's assistive devices logs, interviews with a RN and the DOC.
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WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

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

Non-compliance with: LTCHA, 2007 s. 24 (1) 2

The licensee has failed to ensure that a person who had reasonable grounds to suspect that neglect of a resident had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary

A resident's progress note documented allegations of abuse and neglect. On the same day, an email alleging neglect of the resident was sent to the home's Administrator.

The incident was not reported to the Director until three days after the home became aware of the concern.

The home's failure to report to the Director immediately after becoming aware of the allegations of neglect of a resident, may have delayed the Director's ability to respond to the incident in a timely manner.

Sources: critical incident report**,** a resident's progress notes**,** the home's investigative notes, and interviews with the DOC, a RN and the Administrator.
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WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC#009 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 101 (2)(c)

The licensee has failed to ensure that that a documented record that included the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required was kept in the home for a complaint alleging a resident's neglect and care issues.

Rationale and Summary

A verbal complaint alleging the neglect of a resident was received by a RN. On the same day, an email was sent to the home's Administrator regarding the same issue. In the following three days, additional emails related to care issues of the same resident were received by the home.

The home's complaint records did not include a copy of this complaint with the type of action taken to solve the complaint, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response and any response made in turn by the complainant.

The DOC and the Administrator said that a complaint form was not submitted for this complaint.

Sources: the home's complaints records, a resident's progress notes, the home's investigative notes, and interviews with the Administrator and the DOC.
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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC#010 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. s. 102 (2) (b)

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

Rationale and Summary

According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to IPAC.

A. The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 10.4 (h), indicates that the licensee shall ensure that the hand hygiene program includes policies

and procedures, as a component of the overall IPAC program, as well as support for residents to perform hand hygiene prior to receiving meals and snacks.

The home's hand hygiene policy, documented residents will be offered and encouraged to perform hand hygiene before and after meals and/or snacks.

On one occasion, during the snack service in front of the nursing station and on one of the home areas, two PSWs did not encourage or assist 12 out of 12 residents with hand hygiene before they received their snacks.

On a separate occasion, during the snack service on the same home area, two PSWs did not encourage or assist five out of five residents with hand hygiene before they received their snacks.

On the same day, during the snack service on a different home area, two PSWs did not encourage or assist 11 out of 11 residents with hand hygiene before they received their snacks.

The home's DOC/IPAC Lead and an RN said hand hygiene should have been offered to the residents prior to receiving their snacks.

Gaps in assisting and/or encouraging residents to conduct hand hygiene before they received their snacks, increased the risk of possible transmission of infectious microorganisms.

Sources: observations of the snack service in two home areas, the home's hand hygiene policy, IPAC Standard (April 2022), and interviews with two residents, two PSWs, an RN, and the DOC/IPAC Lead.
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B. The IPAC Standard for Long-Term Care Homes (LTCHs), dated April 2022, section 9.1 (f) documents that the licensee shall ensure that Additional Precautions are followed in the IPAC program and include at minimum additional PPE requirements including appropriate selection application, removal and disposal.

The home's IPAC Policy, indicated that mask and eye protection should be worn when droplet-contact precautions were in place.

The home's COVID-19 policy documented that PPE should be worn in accordance with the most recent available COVID-19 directives and local Public Health guidelines.

According to Directive #5, issued on December 17, 2022, effective December 22, 2022, as an interim precaution in light of the uncertainty around the mechanisms of transmission of the COVID-19 Omicron variant of concern (B.1.1.529), the required precautions for all health care workers providing direct care to or interacting with a suspected, or confirmed cases of COVID-

19 are a fit-tested, seal-checked N95 respirator or approved equivalent, eye protection, gown and gloves.

At the time of this inspection, a resident was on droplet and contact precautions and their test results were pending.

Public Health Ontario (PHO) Droplet and Contact precautions signage was posted on the door of this resident's room. The signage directed staff to wear a mask and eye protection when they were within two meters of the resident.

PHO Signage of removal of PPE directed staff to remove eye protection and mask or N95 respirator prior to exiting the resident's room.

On one occasion, an x-ray technician exited the resident's room without removing their eye protection. On the same day, a PSW did not wear eye protection and an N95 respirator before entering in the resident's room and did not change their mask upon exiting the room. Additionally, a different PSW did not wear an N95 respirator before entering in the resident's room and did not change their mask prior to exiting the resident's room.

The home's DOC/IPAC Lead said staff should have worn eye protection before entering in the resident's room where droplet and contact precautions were in place. They also said the eye protection should have been removed and the mask changed prior to exiting the resident's room.

A Public Health (PH) Inspector from Simcoe Muskoka District Health Unit, said that staff should have worn fit-tested, seal checked N95 respirators as indicated in Directive #5, when they were providing care or interacting with suspected COVID-19 cases.

Not wearing the required N95 respirators as required there was a potential risk of spreading COVID-19 to other residents, staff and visitors.

Sources: a resident's clinical records, observations of a resident's room, Directive #3 for Long-Term Care Homes under the Fixing Long-Term Care Act, 2021, May 3, 2022, Directive #5 (issued December 17, 2021), IPAC Standard (April 2022), the home's IPAC and COVID-19 policies, and interviews with two PSWs, the DOC/IPAC Lead, and a PH inspector.
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WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC#011 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 272

The licensee has failed to ensure that the home carried out the policy directive for active screening of all individuals entering the home.

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In accordance with the Chief Medical Officer of Health's (CMOH) COVID-19 Directive #3 for Long-Term Care Homes under the Fixing Long-Term Care Act, 2021 issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7, the licensee was required to ensure active screening of all persons entering the long-term care home.

Rationale and Summary

On one occasion, a visitor was allowed to enter the home without completing all screening questions when the home's electronic screening system did not work. Their screening responses were not evaluated to ensure screening was passed.

The home's DOC/IPAC Lead said that every individual entering the home should be actively screened and if the electronic screening system was not working, a hard copy of the screening questions was to be used.

Not actively screening all individuals for symptoms and exposure history for COVID-19 before they entered the home, put residents, staff, and visitors at risk of possible COVID-19 exposure.

Sources: observation of active screening, Minister's Directive: Directive #3 for Long-Term Care Homes under the Fixing Long-Term Care Act, 2021, effective May 3, 2022, and interviews with a screener and the DOC/IPAC Lead.
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WRITTEN NOTIFICATION: HOUSEKEEPING

NC#012 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with O. Reg. 242/22 s. 93(2)(b)(iii)

The licensee has failed to comply with the housekeeping procedures for cleaning and disinfection of contact surfaces.

Rationale and Summary

In accordance with O. Reg 246/22 s. 11 (1) b, the licensee is required to ensure that there is a housekeeping procedure to clean and disinfect contact surfaces and must be complied with.

The home's IPAC Policy, section Environmental Cleaning, indicated that high-touch surfaces, including but not limited to light switches and fixtures, door handles, ledges, sills and wall-mounted devices shall be cleaned and disinfected at least daily.

The home's Housekeeping Weekend Job Tasks checklists for a three-month period, did not include cleaning of high touch surfaces in residents' rooms and the common areas. The checklist directed staff to clean the handrails if they had time.

The Housekeeping Weekend job task checklist on a particular month, showed missing documentation for cleaning of handrails on four weekend days.

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A housekeeping staff said they were not able to clean the high-touch surfaces on the weekends because of staffing shortages.

The home's DOC/IPAC Lead, and the Housekeeping Supervisor said the high touch areas should be cleaned at least once daily.

By not ensuring that the high-touch surfaces were cleaned at least daily in the weekends was a potential risk of spreading harmful microorganisms throughout the home.

Sources: Directive #3 for Long-Term Care Homes under the Fixing Long-Term Care Act, 2021, May 3, 2022, the home's Housekeeping Weekend Job Tasks checklists, the home's IPAC policy, Environmental Cleaning section, and interviews with a housekeeping staff, the Housekeeping Supervisor, and the DOC/IPAC Lead.
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