If you require this information in an alternate format, please contact the Accessibility Coordinator at accessibility@northumberland.ca or 1-800-354-7050 ext. 2327

Report 2024-087

Report Title: **2024 Ministry of Long-Term Care Inspection Reports Update**

Committee Name: Community Health

Committee Meeting Date: July 30, 2024

Prepared by: Alanna Clark
Administrator
Golden Plough Lodge

Reviewed by: Glenn Dees
Director, Health and Human Services
Golden Plough Lodge

Approved by: Jennifer Moore, CAO

Council Meeting Date: August 14, 2024

Strategic Plan Priorities: ☐ Innovate for Service Excellence
☐ Ignite Economic Opportunity
☒ Foster a Thriving Community
☒ Propel Sustainable Growth
☐Champion a Vibrant Future

Information Report

"**That** the Community Health Committee receive Report 2024-087 '2024 Ministry of Long-Term Care Inspection Reports Update' for information; and

Further That the Committee recommend that County Council receive this report for information."

Purpose

This report for information will provide an overview of the three Golden Plough Lodge's (GPL) Ministry of Long-Term Care Inspection Reports, received to date for 2024.

Background

The GPL is a municipally owned and operated long term care home. The Province mandates every upper tier municipality to have at least one long-term care home in operation. First

established in the 1850's as a County House of Refuge, the GPL has a long-established history of caring for others.

Today, the GPL serves others whose needs cannot be met in the community and require both personal care and nursing expertise. The GPL is first and foremost home to 151 residents, cared for and supported by 230 dedicated staff members providing Nursing Care, Dietary Services, Life Enrichment Programming, Environmental Services and Administration Support.

As an operating division of the Corporation of the County of Northumberland, the following core values are embedded in all facets of the GPL operations:

- Accountability
- Care & Support
- Collaboration/Communication
- Honesty & Integrity
- Innovation & Excellence
- Mutual Trust and Respect

The GPL operates on an annual budget of $23,945,474 (2024). Of that $13,312,827 is funded from Provincial subsidies, $6,982,034 County levy, $3,529,313 resident accommodation revenue and $121,300 other revenues. The bulk of the Provincial subsidies is in the form of a per diem based on occupied beds under various funding envelopes. The largest funding envelope is for nursing and personal care, and this is adjusted by a Case Mix Index factor dependent on the reported acuity levels of the resident population.
The Ministry of Long-Term Care (MLTC) Inspections Branch has visited the GPL three times to date in 2024.

The MLTC conducted a proactive compliance inspection from February 12-16, 2024. The GPL received the follow up Inspection report on February 26, 2024. This is an annual inspection which reviewed the following protocols:

-Resident care and support services
-Skin and Wound Prevention and Management
-Residents' and Family Councils
-Medication Management
-Food. Nutrition and Hydration
-Safe and Secure Home
-Infection Prevention and Control
-Quality Improvement
-Pain Management
-Falls Prevention and Management

The Ministry conducted an inspection of critical incidents and Infection Prevention and Control from May 22-29, 2024, and June 3-7, 2024. The follow up Inspection Report was received on June 26, 2024. Five critical incidents were reviewed which related to the following protocols that were inspected:

- Infection Prevention and Control
- Safe and Secure Home
- Prevention of Abuse and Neglect

- Staffing, Training and Care Standards

The Ministry also conducted an inspection from June 3-7, 2024, related to one critical incident. The follow up inspection report was received on July 5, 2024.The protocols inspected related to this critical incident were:

- Housekeeping, Laundry and Maintenance Services
- Medication Management
- Infection Prevention and Control
- Safe and Secure Home
- Falls Prevention and Management
- Restraints/Personal Assistance Services Devices (PASD) Management

From June 3-7, 2024, there were two inspectors onsite conducting two separate inspections. An Inspection Manager was also onsite from June 3-7, 2024. Her role as communicated was to observe.

During all three exit interviews, the inspectors were complimentary of the home, stating that GPL staff were friendly and welcoming. They also stated information requested was provided in a timely manner which was appreciated.

For clarification, long-term care homes must report critical incidents to the Ministry as defined in legislation. Long-term care homes identify each critical incident using incident categories. If an incident appears to fall into more than one category, the most appropriate incident category is selected. A critical incident is completed for a variety of reasons including but not limited to a missing or unaccounted for controlled substance, contamination of drinking water supply, suspected neglect or abuse of a resident.

A Written Notification may be issued when a non-compliance is identified as low impact or risk to a resident. A Compliance Order will be issued when a non-compliance is identified as significant impact or risk to a single resident's health, safety or quality of life, or moderate impact or risk to multiple residents. If an inspector finds non-compliance with the Fixing Long-term Care Act (FLTCA) during an inspection, they are required by the Act to take the following factors into account:

- Severity
- Scope
- Compliance History.

<u>Severity:</u>

An inspector determines severity based on:

1. The impact to the resident(s) as a result of the finding of non-compliance.

2. The risk to the resident(s) at the time of the non-compliance.

3. The risk to the resident(s) at the time of the inspection (when relevant).

Scope:

An inspector determines scope based on how many residents were affected by the non-compliance. For example, is the finding of non-compliance an isolated incident or a broader issue in the home.

Compliance History:

A licensee is considered to have a history of non-compliance related to a finding if they have a previous finding of non-compliance on the same specific legislative reference (or equivalent in the Long-Term Care Homes Act, 2007) in the past 36 months.

To further explain compliance history, the GPL would have to have no findings for 36 months in an inspection protocol like, Infection Prevention and Control Program (IPAC), to be clear of repeat orders and AMP's. A staff member could be found to be out of compliance by for example, missing one handwashing opportunity, forgetting a step in donning/doffing procedure, misreading a precautions sign and so on. These are important measures that GPL take seriously and when performed, minimize the spread of infectious diseases and provide a safe home for residents. Striving for continuous quality improvement is key and training, repetition and on the spot audits reinforcing best practice behaviour and correcting mistakes are ways to improve IPAC practices within a long-term care home.

Consultations

The GPL senior management team routinely reviews all Inspection Reports upon receipt to initiate corrective actions if required. The GPL continues to work collaboratively and proactively with the HKPR District Public Health Unit to ensure IPAC protocols and mandates are followed

Consultations were completed with:

- leaders in other homes across the Eastern region of Ontario

- Northumberland County CAO and Director of Health and Human Services

- Ministry of Long-Term Care Inspection Manager

Legislative Authority / Risk Considerations

Ministry of Long-Term Care (MLTC)

Fixing Long-Term Care Act, 2021

Ontario Regulation 246/22

Discussion / Options

Ministry Findings

There were no Ministry Findings of non-compliance from the annual proactive compliance inspection. The GPL received 15 written notifications and 9 compliance orders from the May and June inspections. Of the 9 orders, two resulted in administrative monetary penalties (AMP's) totaling $36,000.

Recognizing multiple findings from two of the inspections, this is indicative of what is being realized overall for all homes as inspections become more stringent in a heavily legislated sector with minimal latitude.

An action plan has been prepared and to date the following actions have been implemented to return to compliance with the Ministry of Long-Term Care regulations under the FLTCA, 2021. The focus is on coming into compliance with the 9 Ministry orders and then secondly, the written notifications.

Further to actioning items noted in these inspections, staff will review opportunities for sourcing external expertise to conduct preparatory reviews for future inspections. This will assist in highlighting areas for improvement. Recognizing extent of requirements under the FLTCA and level of scrutiny seen in latest inspections this will help but would not alleviate likelihood of future findings.

Orders

A/C and Air temperature

1) **Non-compliance with: O. Reg. 246/22, s. 23.1 (1)** Air conditioning requirements s. 23.1 (1) Every licensee of a long-term care home shall ensure that air conditioning is installed, operational and in good working order for the purpose of cooling the temperature in the following areas of the long-term care home during at least the period from May 15 to September 15 in each year: 1. Every resident bedroom. 2. Every designated cooling area, in the case of a home without central air conditioning. O. Reg. 66/23, s. 4.

*The Licensee has failed to comply with FLTCA, 2021 **Notice of Administrative Monetary Penalty AMP #001 Related to Compliance Order CO #001**

2) **Non-compliance with: O. Reg. 246/22, s. 23.2 (4)** Uninstalling portable or window air conditioning s. 23.2 (4) A licensee who uninstalls or does not install a portable air conditioning unit or a window air conditioning unit in accordance with a resident's request shall promptly include in the plan of care for each resident in the room, (a) any specific risk factors that may lead to heat related illness as a result of the lack of an air conditioning unit; and (b) the specific interventions and strategies that staff are to implement to prevent or mitigate the identified risk factors that may lead to heat related illness.

3) **Non-compliance with: O. Reg. 246/22, s. 23.2 (8)** Uninstalling portable or window air conditioning s. 23.2 (8) In all cases where portable air conditioning units or window air conditioning units are uninstalled or not installed pursuant to this section, the units must remain accessible and available for use, (a) at the request of any one or more of the residents who reside in the bedroom; or (b) when required to cool and maintain the temperature of the bedroom for the health, safety and comfort of the residents in that bedroom.

4) **Non-compliance with: O. Reg. 246/22, s. 24 (4)** Air temperature s. 24 (4) In addition to the requirements in subsection (2), the licensee shall ensure that, for every resident bedroom in which air conditioning is not installed, operational and in good working order, the temperature is measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m. on, (a) every day during the period of May 15 to September

15; and (b) every other day during which the outside temperature forecasted by Environment and Climate Change Canada for the area in which the home is located is 26 degrees Celsius or above at any point during the day.

Actions: A/C, Air temperature- Order to comply by July 12, 15, 2024 and August 9, 2024

Air conditioner units have been installed in every resident room. Audits of all residents to see if they decline air conditioning install with documentation in care plan completed. Nursing plan of care includes risk factors that may lead to heat related illness and specific interventions as a result of not having air conditioning completed. There is an air conditioning unit readily available for install for every resident who opts out of air conditioning based on audit. Moving forward for every resident room without A/C a temperature will be taken and documented once daily between 12-5pm. This process has been communicated to all responsible for taking these temps. Currently undergoing audit of recorded temperatures daily for 2 weeks and then weekly for 4 weeks.

Resident rooms were not all fully equipped with A/C units at the time of inspection, however regular temperature checks to ensure rooms were within the acceptable range of 22 degrees Celsius to 26 degrees Celsius were completed. All residents also continue to have access to cooling rooms such as the auditorium as needed based on weather conditions. Hallways are equipped with air chillers providing a cool space as well. The delay in installing A/C units in every resident room is related to the delays in construction of the new GPL building. It was previously understood that the GPL would move into the new build well before the Ministry ordered all homes to become fully air conditioned. Resident care and comfort were and continue to be a priority within the GPL for all residents.

Training

1) **Non-compliance with: FLTCA, 2021, s. 82 (2)** Training s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below: 1. The Residents' Bill of Rights. 2. The long-term care home's mission statement. 3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 4. The duty under section 28 to make mandatory reports. 5. The protections afforded by section 30. 6. The long-term care home's policy to minimize the restraining of residents. 7. Fire prevention and safety. 8. Emergency and evacuation procedures. 9. Infection prevention and control. 10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 11. Any other areas provided for in the regulations.

Actions: Training- Order to comply by July 30, 2024

Currently providing training in all areas required under FLTCA, 2021, s. 82 (2) to all Security staff/ any other Agencies working in home. There will be a written record of all training along with a record of demonstrated knowledge of the training for the Ministry to review. This record will include what training was provided, who provided the training, a record of the knowledge test, the date and time the education was provided as well and the name and signature of the Agency staff who received this training.

Currently developing a process to ensure that all Agency staff and all newly hired staff, receive the required training under FLTCA, 2021, s. 82 (2) as well as any other required training specific to their role, prior to working in the home.

Currently conducting an audit of all Agency staff who work at the GPL, as well as all staff hired in the home from January 1, 2023, to present, to ensure that all required training has been completed and there is a documented record of this training.

Infection Prevention and Control Program

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.)

Ministry Inspector observations and interviews with 9 direct care staff.

*The Licensee has failed to comply with FLTCA, 2021 **Notice of Administrative Monetary Penalty AMP #002 Related to Compliance Order CO #006**

Compliance History:
Prior non-compliance with O. Reg 246/22, s.102 (2) (b), resulting in:
-WN issued on July 07, 2022, in #2022-1553-0001
-CO issued on July 07, 2022, in #2022-1553-0001

This is the second AMP that has been issued to the licensee for failing to comply with this requirement. The infection prevention and control program would have to be without findings for 36 consecutive months in order to be clear from repeat AMP's.

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

Ministry inspector observed one direct care staff.

Actions: Infection Prevention and Control Program- Order to comply by July 30, 2024 and August 5, 2024

Currently developing and implementing a process to ensure that donning and doffing is completed by staff as per IPAC Best Practice standards for every resident who requires additional precautions. Also, PPE disposal bins have been made available in the appropriate locations, inside the resident's bedroom, as per the Best Practice vs. outside of rooms. Currently providing training on the four moments of hand hygiene to staff mentioned in the order. Conducting three random audits over a period of three weeks for each staff member.

A process has been developed and implemented to ensure that 70-90% Alcohol Based Hand Rub (ABHR) is readily available at all times, in common areas and at the point of care, including medication carts, treatment carts, snack carts and multi-use equipment such as blood pressure

machines. Currently conducting audits twice a week for 4 weeks of every home area to ensure the hand sanitizer is readily available.

Recreational Cannabis

1) **Non-compliance with: O. Reg. 246/22, s. 142 (1)** Recreational cannabis
s. 142 (1) Every licensee of a long-term care home shall ensure that there are written policies and procedures to govern, with respect to residents, the cultivation, acquisition, consumption, administration, possession, storage and disposal of recreational cannabis in accordance with all applicable laws, including, without being limited to, the Cannabis Act (Canada) and the Cannabis Regulations (Canada).

Actions: Recreational Cannabis- Order to comply by July 29, 2024

Currently creating and implementing a Recreational Cannabis Policy and process for residents which adheres to the legislated requirements. Once created, all direct care staff will be trained on the Recreational Cannabis policy and procedure.

Hiring Staff, Accepting Volunteers

1) **Non-compliance with: O. Reg. 246/22, s. 252 (3)** Hiring staff, accepting volunteers
s. 252 (3) The police record check must be a vulnerable sector check referred to in paragraph 3 of subsection 8 (1) of the Police Record Checks Reform Act, 2015, and be conducted to determine the person's suitability to be a staff member or volunteer in a long-term care home and to protect residents from abuse and neglect.

Actions: Hiring staff, accepting volunteers- Order to comply by July 30, 2024

Currently working to create a process to ensure that all staff hired to work at the GPL, including Agency staff, provide a police record check with a vulnerable sector screening, prior to working in the home. Currently undertaking a review of the HR files for all staff hired since January 2023 to present, including Agency staff, to ensure that a valid police record check was completed and is retained on file. If valid police checks are identified as missing, that staff or Agency staff member will immediately apply for a police record check with a vulnerable sector screening and may not work until the valid document is provided. Primarily, this was related to individuals working in the home through contracted services.

Notifications

Duty to Protect

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.

Actions: Duty to Protect- Written notification

Planning education on resident care and skin integrity for staff involved in Ministry observations.

Responsive Behaviours

1) **Non-compliance with: O. Reg. 246/22, s. 58 (3) (c)** Responsive behaviours s. 58 (3) The licensee shall ensure that, (c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.
2) **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.

Actions: Responsive Behaviours- Written notification

In the process of updating the responsive behaviours evaluation and ensuring a process is in place to update program evaluations as per Ministry requirements.

Infection Prevention and Control Program

1) **Non-compliance with: O. Reg. 246/22, s. 102 (7) 3.** 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: 3. Overseeing the delivery of infection prevention and control education to all staff, caregivers, volunteers, visitors and residents.

Actions: IPAC- Written notification

The Ministry inspector observed one volunteer student bring a resident to the dining room without washing their hands. All staff, including volunteers to be included in IPAC and staff orientation training.

Visitor Policy

1) **Non-compliance with: O. Reg. 246/22, s. 267 (1) (c)** Visitor policy s. 267 (1) Every licensee of a long-term care home shall establish and implement a written visitor policy which at a minimum, (c) complies with all applicable laws including any applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act.

Actions: Visitor Policy-Written notification

Continuing to monitor updated visitor logs and explore digital options for visitor/volunteer sign in/out.

Home to be Safe and Secure Environment

1) **Non-compliance with: FLTCA, 2021, s. 5** Home to be safe, secure environment s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents

Actions: Home to be safe and secure environment- Written Notification

Ensured tub room doors are closed and locked at all times.

Plan of Care

1) **Non-compliance with: FLTCA, 2021, s. 6 (1)** (c) Plan of care s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.
2) **Non-compliance with: FLTCA, 2021, s. 6 (9) 1**. Plan of care s. 6 (9) The licensee shall ensure that the following are documented: 1. The provision of the care set out in the plan of care.
3) **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.
4) **Non-compliance with: FLTCA, 2021, s. 6 (10)** (b) Plan of care 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.

Actions: Plan of Care- Written Notification

Develop plans to ensure plan of care sets out clear directions to staff related to resident's falls prevention interventions and the use of a tilt wheelchair, and seatbelt restraint. Also exploring interventions to ensure timely and accurate documentation in care plans through the use of technology i.e. setting mandatory fields and update time in the care management system. Care plans are unique and should reflect the care needs of each resident. This message will be reinforced with all care staff through education.

Requirements relating to restraining by a physical device

1) **Non-compliance with: O. Reg. 246/22, s. 119 (2) 3**. Requirements relating to restraining by a physical device s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act: 3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
2) **Non-compliance with: O. Reg. 246/22, s. 119 (2) 4.** Requirements relating to restraining by a physical device s. 119 (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 35 of the Act: 4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition themself.
3) **Non-compliance with: O. Reg. 246/22, s. 119 (7) 4.** Requirements relating to restraining by a physical device s. 119 (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 35 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 4. Consent.

Actions: Requirements relating to restraining by a physical device- Written notification

Opportunity to review, update as needed and disseminate Restraints Policy to ensure accurate practice and documentation of practice as it relates to restraints use.

Minimizing Restraints

1) **Non-compliance with: O. Reg. 246/22, s. 122** (a) Evaluation s. 122. Every licensee of a long-term care home shall ensure, (a) that an analysis of the restraining of residents by use of a physical device under section 35 of the Act or pursuant to the common law duty referred to in section 39 of the Act is undertaken on a monthly basis.

Actions: Minimizing restraints- Written notification

Opportunity to review, update as needed and disseminate Restraints Policy to ensure accurate practice and documentation of practice as it relates to restraints use.

Administration of Drugs

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)

Actions: Administration of Drugs-Written notification

Opportunity to review care staff's understanding of how to safely and accurately administer drugs to all residents on the floor. Going forward medication administration will be complete and documented for each resident before moving on to the next resident medication pass.

Upon consultation with other municipally owned long-term care homes in the Easter Region, many are experiencing lengthy, in-depth investigations similar to the experience in May/June at the GPL. Over the course of the inspection period, inspectors conducted several interviews (with many repeat interviews), observed and requested multiple records for their review. At one home, an inspector called back to conduct interviews on an inspection that was already closed. While not formally announcing a shift in inspection methodology, it appears inspectors are taking deep dives into their inspections, staying for longer periods and providing multiple findings of non-compliance. There are multiple areas for improvement as noted in the aforementioned Ministry reports, and GPL staff, lead by senior leadership, will focus on the areas listed to ensure we are prepared for follow up inspections. Senior leadership, namely the Administrator of the GPL will continue to develop and grow professional relationships with the Ministry of Long-Term Care staff. All staff will continue to offer a welcoming, positive and safe environment for everyone.

Financial Impact

Notice of Administrative Monetary Penalty AMP #001 Related to Compliance Order CO #001 Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $25,000.00, to be paid within 30 days from the date of the invoice.

Notice of Administrative Monetary Penalty AMP #002 Related to Compliance Order CO #006 Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11,000.00, to be paid within 30 days from the date of the invoice.

Member Municipality Impacts

N/A

Conclusion / Outcomes

GPL senior management request that the Community Health Committee and County Council receive this report for information.

Attachments

1) Report 2024-08 ATTACH 1 ‘Inspection Report under the Fixing Long-Term Care Act, 2021 (June 26, 2024)

2) Report 2024-08 ATTACH 2 ‘Inspection Report under the Fixing Long-Term Care Act, 2021 (July 5, 2024)