Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 18, 2020	2020_603194_0014	000302-20	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Warkworth Place
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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 8, 9 and 10, 2020

The Inspector completed a log related to improper care of a resident

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Program Manager (PM), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Housekeeper and residents.

The inspector reviewed clinical health records of identified residents, COVID-19 screening logs, internal abuse investigation documentation, staff educational records, relevant policies for abuse, lift/transfer and COVID screening. The Inspector observed staff to resident care and infection control practices.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that it's abuse policy was complied with related to immediate reporting and investigating.

Review of the licensee's abuse policy directed that registered staff were to immediately notify management if there was any suspected/reported abuse and immediately investigate.

Resident #001 complained of pain during a transfer by PSW's The use of the incorrect equipment placed the resident at risk of harm. RN #104 did not notify management of the incident until two days later. The investigation into the incident was started by Director of Care (DOC) two days later.

The Administrator verified that registered staff at the home were to immediately notify management and start an investigation, when abuse incident was reported.

Sources: Resident #001 plan of care, the homes internal investigation, Policy for Zero Tolerance of Resident Abuse and Neglect. Interviews with the resident, DOC, Administrator and RN #104 and other staff. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the infection prevention and control program was complied with, when COVID-19 screening of staff and essential visitors was not preformed when entering and leaving the home.

The IPAC assessment and Directive #3 stated that COVID-19 screening and temperature checks of staff and essential visitors were to be preformed when entering and leaving the home.

On September 9, 2020 when Inspector #194 was leaving the home, there was no staff at the front door to complete the COVID-19 screening. The lack of COVID-19 screening placed the home at risk for potential infections.

Review of the staff COVID-19 screening logs for three days identified that the screening questions and temperatures were not recorded for a number of staff when leaving the home. Review of the essential visitors COVID-19 screening logs for the period of seven days, identified that the screening questions and temperatures were not recorded for the majority of the essential visitors when leaving the home.

PSW #105 stated that they were aware that temperatures were to be recorded when leaving the home but not aware that the COVID-19 screening questions had to be completed. Interviews with RN #112 and other staff indicated that they were aware that the staff needed to perform COVID-19 screening and temperature checks when entering and leaving the home.

The DOC stated that the COVID-19 screening for staff was being preformed by the nursing staff when entering the home and that staff were responsible for performing the COVID-19 screening questions and temperature checks when leaving the home.

Sources: IPAC assessment, Directive #3, COVID-19 screening logs for staff and essential workers. Interviews with the DOC, Administrator, PSW #102 and other staff. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that all staff participate in the implementation of the Infection prevention and control program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 was provided with the correct equipment during transfer.

PSW's #102 and #103 transferred resident #001 using equipment not directed in the plan of care, placing the resident at risk of harm. PSW #102 stated that they were aware that the resident's plan of care stated that specific equipment was to be used during transfers.

DOC verified that PSW staff were to use the equipment identified in the plan of care for resident #001.

Sources: Resident #001 plan of care, internal investigation, Interviews with DOC, Administrator, resident and others. [s. 36.]

Issued on this 18th day of September, 2020

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.