Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 9, 2018	2018_670571_0002	000992-18	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Hope Street Terrace
20 Hope Street South PORT HOPE ON L1A 2M8

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

PATRICIA MATA (571), JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): January 15,16,17,18,19, 22, 23, 24 and 25, 2018

In addition, the following Critical Incident logs were inspected:
022589-17 an allegation of staff to resident abuse

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Clinical Care Coordinator (CCC), Registered Dietitian (RD), the Recreation Manager (RM), Activity Aides (AA), the Nutrition Manager (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and housekeeping staff, residents and families.

In addition, clinical health records, policies, Resident council meeting minutes, meeting minutes related to the medication program, the licensee's investigation notes and administrative records were reviewed. In addition, resident care and staff to resident interactions were observed.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

7 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	Legendé 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 O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that medications were stored in an area or a medication cart, that was used exclusively for drugs and drug-related supplies and was secured and locked.

On the second floor, on January 15, 16, 17, 19, 23 and 24, 2018, Inspector #672 observed at several different times during the day that the nursing station gates were left open. No staff were observed to be in the immediate area and there were residents sitting around the nursing station. On the counter of the nursing station were bins of medicated creams. On January 15, 16, 17 and 23, 2018, Inspector #672 observed the same on the third floor at the nursing station.

During separate interviews with RPN #119 and RN #120 on January 23, 2018, both indicated that the expectation in the home was that all medicated creams were to be returned to registered staff after use, and kept locked in the medication room, not left sitting on the counter at the nursing station.

During an interview on January 24, 2018, the DOC indicated that the expectation in the home was that all medicated creams were to be returned to registered staff after use and kept locked in the medication room when not in use and not left sitting on the counter at the nursing station.

The licensee failed to ensure that medicated creams were stored in an area or a medication cart, that was used exclusively for drugs and drug-related supplies, which was secured and locked. [s. 129. (1) (a)]

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 for ensuring that, (a) drugs are stored in an area or a medication cart, (i) that is used exclusively for drugs and drug-related supplies and (ii) that is secure and locked, 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 all staff participate in the implementation of the infection prevention and control program.

The home was in an active Outbreak during the inspection, for both gastrointestinal and respiratory illnesses. On January 15, 2018, Inspector #672 observed the morning nourishment service on the second floor. PSW #103 was observed to be walking in and out of resident rooms, including rooms with contact and droplet precautions posted, serving residents nourishments, without donning any personal protective equipment (PPE), nor completing hand hygiene.

During an interview on January 15, 2018, PSW #103 acknowledged that the expectation in the home was that hand hygiene should be completed between serving residents, and following any contact with residents and high touch surfaces. PSW #103 further indicated that PPE was required if they was serving residents with active illnesses which required contact/droplet precautions, and entering their personal space. PSW #103 indicated that infection control practices were not followed during the nourishment pass due to being behind schedule, therefore they was rushing to complete the nourishment cart, and the requirements had temporarily slipped their mind.

On January 17, 2018, Inspector #672 observed the Staff Member (SM) #112 complete the afternoon nourishment service on the second floor. During the nourishment pass, SM #112 was observed to assist a resident from their wheelchair into a stationary chair, remove used dishes from resident rooms, and enter/exit isolation rooms, without completing an episode of hand hygiene. SM #112 was also observed to touch the cookies being served with bare hands, to place them into a napkin, which were then served to residents.

During an interview on January 17, 2018, SM #112 indicated not being aware of hand hygiene policies within the home, or the expectations regarding hand hygiene and PPE when entering/exiting an isolation room.

During an interview on January 15, 2018, the DOC indicated that the expectation in the home was that infection prevention control practices were to be followed at all times, including hand hygiene during the nourishment passes. The DOC further indicated that all staff had been trained regarding infection control practices, specifically hand hygiene and the usage of PPE. The DOC indicated that PPE was required when staff were entering the personal space of residents who required precautions due to gastrointestinal or respiratory illnesses, and hand hygiene was required between serving each resident, following any physical assistance of a resident, and touching any high touch surface.

The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program, specifically related to hand hygiene during nourishment passes. [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 for 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #006's Subtitute Decision Maker (SDM) was provided the opportunity to participate fully in the development and implementation

of the plan of care.

Inspector #672 reviewed the health care records for resident #006, and noted a Physician's Order on a specified date, related to a specified medication. The physician's order sheet indicated that the order had been double checked by two registered staff, but the box related to notification of the SDM did not have a signature in it.

During an interview on January 23, 2018, RPN #113 indicated that they had second checked the Physician's order, and did not notify resident #006's SDM, as they had assumed that the RN who processed the order had completed the notification. RPN #113 indicated that if the SDM had been notified, the expectation in the home was that a progress note would be written regarding the notification.

Inspector #672 reviewed the progress notes for resident #006 for a specified time period, there was no indication that the SDM was notified of the medication changes.

During an interview with Inspector #672 on January 23, 2018, the Clinical Coordinator indicated that all registered staff received a full orientation regarding processing Physician's orders, and notification of SDMs prior to working on the nursing units. The Clinical Coordinator further indicated that the expectation in the home was that all residents and/or SDMs were notified prior to implementing any new Physician's order, to ensure rationale for the order was explained, and permission was received. Following notification of the SDM, the nurse should document in the resident's progress notes that SDM was notified.

The nurse who completed the initial processing of the Physician's order was not available for an interview during the inspection.

The licensee failed to ensure that resident #006's SDM was provided the opportunity to participate fully in the development and implementation of the plan of care, specifically related to a specified medication. [s. 6. (5)]

2. The licensee has failed to ensure that the care set out in the plan of care for resident #028 was provided to the resident as specified in the plan.

Related to log #022089-17:

On January 24, 2018, Inspector #672 reviewed the most recent written plan of care for resident #028, which indicated that resident #028 was to receive specified care, in a specified manner and at specified times of the day.

During separate interviews on January 24, 2018, PSW #103 and #125 both indicated that resident #028 did not receive the specified care, in the specified manner at specified times of the day as outlined in the plan of care but rather the specified care was provided in a different manner.

During an interview on January 25, 2018, the DOC indicated the expectation in the home was the written plans of care for each resident were kept up to date and current with active and effective interventions, and that the assistance provided to each resident be provided to the resident as specified in the plan.

The licensee failed to ensure that the care set out in the plan of care for resident #028 was provided to the resident as specified in the plan. [s. 6. (7)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept locked when not in use, and supervised by staff.

The following observations were made by Inspector #672 on January 15, 2018:
-on the 2nd floor, the bathing room across from the nursing station was observed to be

unlocked. Inside the bathing area, there was a large puddle on the floor to the right of the tub. There was a small "Utility Room" within the bathroom, which was also unlocked. Within this room was a dishwasher, with "Sunlight" dishwasher cleaner, and a box of Coloplast Baza Cleanser. Across from this room was a cupboard, which stored personal care supplies, such as razors, sharps container and mouthwash. There was also ED Every Day Disinfectant spray, Accel Wipes, Oxivir TB wipes, and a large bottle of Listerine mouth wash. While Inspector #672 was completing the inspection of the room, a resident entered independently, without staff assistance.
-on the 2nd floor, the bathing room down the west hall was observed to be unlocked. The cupboard above the sink in this room had a sign to "Keep Locked at All Times", which was unlocked. Within the cupboard was a bottle of "Old Spice" After Shave, a sharps container with used razors within, Coloplast perineal cleanse and ED Every Day Disinfectant.
-on the third floor, the bathing room across from the nursing station was observed to be unlocked. There was a dishwasher and a box of "Sunlight" dishwasher cleaner on a counter, along with a box of Cavilon Barrier, and personal care supplies, including disposable razors. There was an unlocked closet in the room with a sharps container with used razors, and clean disposable razors and mouthwash were also stored in the closet.
-the bathing area down the west hall was observed to be unlocked. Within the room, the cupboard had personal care supplies, such as an open bag of disposable razors. No staff were observed to be in the area, and there were residents wandering in the hallway, just outside of the room.

In addition, Inspector #672 observed the following:
-the bathing room in the west hall of the second floor was unlocked. No staff were observed to be in the area, and there were residents wandering in the hallway, just outside of the room on January 17, 19, 22, 23 and 24, 2018
-the bathing room across from the nursing station, on the second floor was unlocked. No staff were observed to be in the area, and there were residents wandering in the hallway, just outside of the room on January 17 and 19, 2018.
-the bathing room across from the nursing station on the third floor was unlocked and accessible to residents with no staff observed to be in the area and there were residents wandering in the hallway, just outside of the room on January 16, 19 and 24, 2018.

During an interview with the Housekeeping Supervisor #110, on January 18, 2018, at 1045 hours, the Housekeeping Supervisor indicated that when the bathing areas were not in immediate use, the expectation in the home is that the doors are to be kept locked

at all times.

During separate interviews on January 24, 2018, RPN #113 and the DOC indicated that when the bathing areas were not in immediate use, the expectation in the home is that the doors are to be kept locked at all times.

The licensee failed to ensure that all doors leading to non-residential areas were kept closed and locked at all times, when not in use, and supervised by staff. [s. 9. (1) 2.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident had their personal items labelled within 48 hours of admission, and in the case of new items, of acquiring.

On January 15, 2018, Inspector #672 made the following observations:

In the bathing area down the west hall of the second floor, there was a half empty, unlabelled bottle of "Old Spice" aftershave, an unlabelled, used, green hair brush on the counter, and an unlabelled bottle of Tres Semme conditioner beside the tub.

During separate interviews on January 15, 2018, PSW #105 and PSW #106 acknowledged that the items appeared to have been used, and were unable to state who the items belonged to.

In the bathing area across from the nursing station on the third floor, there was an

unlabelled "Zest" soap beside the tub; an unlabelled bottle of "Bayliss and Harding" bath foam, unlabelled bottles of "Julian" and "Temptations" perfume; one unlabelled purple loufa and one unlabelled white loufa, both appeared to have been used; and one unlabelled, used, silver hair brush.

During an interview with Inspector #672 on January 15, 2018, PSW #104 acknowledged that the unlabelled items appeared to have been used, and was unable to state who the items belonged to.

In the bathing area down the west hall of the third floor, there was an unlabelled roll on "Speed Stick" deodorant, an unlabelled jar of "Cold Cream" and an unlabelled jar of "Bath Scents" cream.

During an interview with Inspector #672 on January 15, 2018, PSW #108 was unable to state who the items belonged to, except that the Cold Cream was "years old", and believed the Bath Scents may have belonged to a resident "who passed away last year".

On January 16, 2018, Inspector #672 made the following observations:

In a specified room, there was an unlabelled urinal on the back of the toilet, an unlabelled green bar of soap beside the sink, and an unlabelled can of shaving cream, in the shared bathroom.

In a specified room, there was an unlabelled urine collection "hat", along with an unlabelled can of shaving cream, and an unlabelled jar of moisturizer, in the shared bathroom.

In a specified room, there was an unlabelled, used, blue hair brush, and an unlabelled slipper pan on the floor under the sink in the shared bathroom.

On January 16, 2018, Inspector #571 made the following observations:

In a specified room, there was an unlabelled urine specimen collection "hat" and an unlabelled urine bottle inside a bag, sitting on the back of the toilet.

In a specified room, there was an unlabelled bed pan under the sink in the shared bathroom.

In a specified room, there was an unlabelled bed pan under the sink in the shared bathroom.

During an interview on January 18, 2018, the Clinical Coordinator indicated the expectation in the home was that all personal care items were labelled with each resident's name on it, prior to use.

The licensee failed to ensure that every resident had their personal items labelled within 48 hours of admission, and in the case of new items, of acquiring. (672) [s. 37. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004 received a skin assessment by a member of the registered nursing staff as specified in the LTCHA, 2007.

On January 15, 2018, Inspector #672 observed resident #004 to have an area of specified impaired skin integrity. Resident #004 indicated being unsure of the cause of the specified impaired skin integrity, and stated it had been present for a specified period of time.

Inspector #672 reviewed the progress notes in Point Click Care (PCC) for a specified time period. The notes indicated that resident #004 had been absent from the long term care home on a specified date and returned on a specified date.

Review of the clinical health record for resident #004 was completed by Inspector #672. No evidence was observed that resident #004 received a skin assessment, following return to the long term care home.

During an interview on January 19, 2018, RPN #113 indicated that a head to toe skin assessment was to be completed within 24 hours, upon any resident's return to the long term care home.

During an interview on January 19, 2018, the DOC indicated the expectation within the home was that a head to toe skin assessment should be completed, within 24 hours of any resident's return to the long term care home.

The licensee failed to ensure that resident #004 received a skin assessment, completed by a member of the registered nursing staff as specified in the Act. [s. 50. (2) (a) (ii)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council, as there was currently no active Family Council in the home, were held.

During an interview on January 19, 2018, the Administrator indicated that the management team had not conducted semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council during the 2017 year. The Administrator further indicated that the management team had only hosted one meeting during the 2017 year, on February 15, 2017, at 1800 hours, and no other interventions had been attempted to recruit for an active Family Council in the home. The Administrator indicated awareness of the requirements and legislation for semi-annual meetings within the LTCHA.

The licensee failed to, on an ongoing basis, advise residents' families and persons of importance to residents of the right to establish a Family Council; and convene semi-annual meetings to advise such persons of the right to establish a Family Council. [s. 59. (7) (b)]

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Ministère de la Santé et des Soins de longue durée

Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 12th day of March, 2018

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

Original report signed by the inspector.