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**

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111


## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 6, 2020 | 2019_643111_0026 | 021252-19 | 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

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

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

LYNDA BROWN (111)

## 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): December 3 to 6, 9 and 10, 2019**

**A critical incident report (CIR) (Log #021252-19) was completed related to an alleged staff to resident neglect.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the acting Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Infection Prevention and Control Lead (IPAC) and Pharmacist.**

**During the course of the inspection, the inspector: observed the medication room and cart, reviewed resident health records, investigations, employee records and reviewed the following policies: Infection Prevention and Control.**

**The following Inspection Protocols were used during this inspection:**
**Infection Prevention and Control**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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 :**

The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

A critical incident report (CIR) was received by the Director on a specified date for an alleged staff to resident neglect. The CIR indicated on a specified date, the Infection Prevention and Control (IPAC) Lead discovered during a specified period, there was suspected neglect of seven residents (#001, #002, #003, #004, #005, #006 and #007) related to a specified procedure and involved RPN #100 and RN #101. The CIR was later amended and indicated the investigation was concluded and determined to be unfounded. The CIR indicated the home determined that RPN #100 and RN #101 were found to be using improper infection control practices related to a procedure.

Review of the home's infection control policy, Cleaning and Disinfecting Equipment (IC-02-01-11), last updated on October 2019 indicated under procedures:
1.Clean and disinfect non-critical resident care equipment that comes in contact with intact skin of a resident prior to being used with another resident.
2. Label single resident-use equipment with the resident's name and direct staff to use this equipment only for the resident for which it is labelled.
On page 3 of 3, Single resident-use medical device: a device that is used by one resident only, but can be reused for the same resident. It cannot be used or reused with another resident.

During an interview with RPN #102, they confirmed they were the IPAC lead for the home and discovered on three separate dates, where resident care equipment was unlabelled, found in the top of the medication cart on a specified floor and that were in use. The RPN indicated all residents are supposed to have their own labelled equipment to prevent cross contamination. The RPN indicated on a specified date, they completed an audit of all of the resident care devices in use, on a specified floor, during a specified period. The RPN indicated they determined that RPN #100 and RN #101 had completed a procedure on seven residents that did not correlate with any of those residents personal care devices.

During an interview with the Pharmacist, they indicated that all residents are supplied with their own personal use medical device and should be labelled with their names, to ensure that they are only used for that resident.

Observation of all medication carts indicated that all residents with personal care devices in use, were labelled with the resident's names and stored correctly.

A review of the specified Infection Control Audit (completed on a specified date) for a

specified period, indicated a review of the specified medical procedure determined that there were a number of dates when RPN #104 and #105 were noted to be practising improper infection control practices related to the use of resident personal use medical devices. There were also a number of dates when the IPAC lead was unable to determine if the medical procedure was completed for seven residents (resident #001, #002, #003, #004, #005, #006 and #007) by RN #101 and RPN #100.

Review of the employee training records for RN #101, RPN #100 and #104 indicated they all had received annual IPAC training. The training included the cleaning and disinfecting of personal equipment. RPN #105 no longer worked in the home.

During an interview with RPN #100, they indicated all residents are supposed to have their own personal use medical device which is to be labelled and stored correctly for infection control purposes. The RPN indicated some nurses keep one personal use medical device in the top of the drawer of the medication cart and used with all residents and confirmed they also completed this practice. The RPN indicated they no longer complete this improper infection control practice. The RPN confirmed they had completed their annual IPAC and included IPAC practices with the use of resident personal equipment.

During an interview with RN #101, they indicated they usually completed the medical procedure for resident by using one or two resident personal medical devices that were stored in the top drawer of the medication cart for all the residents. The RN confirmed the residents had their own labelled medical device but that it was easier to just grab one. The RN confirmed awareness they were practising improper infection control. The RN confirmed they had received annual training in IPAC related to the use of resident personal care equipment.

During an interview with the acting DOC, they indicated RPN #102 (IPAC lead) discovered on a specified date, that RPN #100 and RN #101 had documented that they completed a medical procedure for the seven residents that was inconsistent with the residents personal use medical devices. The acting DOC indicated after the investigation, they determined that RPN #100 and RN #101 were not following best practices of infection control related to the use of resident personal use medical devices. The acting DOC was not aware that RPN #104 and RPN #105 were also found to be using the same improper infection control practices.

During interview with Administrator, they indicated they were aware of the medication

incident involving RPN #100 and RN #101 that was discovered on a specified date. The Administrator indicated both RPN #100 and RN #101 confirmed they were not following proper infection control practices related to the use of resident personal use medical devices for seven residents. The Administrator was unaware that RPN #104 and RPN #105 were also using the same improper infection control practices.

The licensee has failed to ensure that RPN #100, RN #101, RPN #104 and #105 participated in the implementation of the infection prevention and control program, specifically related to use of resident personal use medical devices.

***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 to ensure that staff participate in the implementation of the infection prevention and control program, specifically around the use of resident glucometers, to be implemented voluntarily.***

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**Issued on this 7th day of January, 2020**

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

**Original report signed by the inspector.**