Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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: November 4, 2022	
Inspection Number: 2022-1147-0001	
Inspection Type: Critical Incident System	
Licensee: CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Sout	
Long Term Care Home and City: Hope Street Terrace, Port Hope	
Lead Inspector Catherine Ochnik (704957)	**Inspector Digital Signature** Catherine Ochnik Digitally signed by Catherine Ochnik Date: 2022.11.25 08:58:51 -05'00'
Additional Inspector(s) Laura Crocker (741753)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 24, 25, 26, 27, 28, 31 and November 1, 2, 2022.

The following intake(s) were inspected:

- Intake: #00003019- related to staff to resident abuse.
- Intake: #00003086- related to staff to resident abuse.
- Intake: #00005101- related to staff to resident abuse.
- Intake: #00006103- related to improper care of a resident.

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

Falls Prevention and Management
Resident Care and Support Services
Reporting and Complaints
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control.

Non-compliance with: O. Reg. 246/22 ***[s. 102 (2) (b) and Additional Requirement 9.1 for Additional Precautions (f)]***

At minimum, Additional Precautions shall include: Additional PPE requirements including appropriate selection application, removal and disposal.

The licensee has failed to ensure that a standard or protocol issued by the Director with respect to infection prevention and control was implemented.

The licensee has failed to ensure that Routine Practices and Additional Precautions were followed in the IPAC program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard).

Specifically, the licensee did not ensure that all staff participated in the implementation of the IPAC program related to additional PPE requirements including appropriate selection, application, removal and disposal as required by Additional Requirement 9.1 Additional Practices (f) under the IPAC Standard.

Rationale and Summary
A staff member was observed donning Personal Protective Equipment (PPE) when entering a resident room which was under enhanced precautions. The staff member did not don eye protection prior to entering the resident's room. In an interview, the staff member acknowledged that eye protection should have been worn prior to entering the room. Signage posted outside the resident room indicated that eye protection in addition to gloves, gown and an N95 mask, was required.

On the same day, another staff member was observed in a resident's room without eye protection and

without an N95 mask. The staff member was observed wearing a gown, gloves and a surgical mask while assisting the resident. In an interview, the staff member acknowledged that they should have donned eye protection and an N95 mask prior to entering the residents room.

In an interview, the IPAC Lead confirmed that eye protection, gowns, gloves and N95 masks were required for resident rooms under enhanced precautions.

The home's policy titled "Use of N95 Respirators" Issue Date: December 2021, indicated that "N95 respirators and eye protection (goggles or face shield) are required by all employees when providing direct care or interacting with all residents on enhanced precautions which includes suspected, probable (i.e. placed in precautions as high-risk contact, in an outbreak zone of the facility or recently transferred from a facility in outbreak) or confirmed cases of COVID-19."

Failure to ensure that staff participated in the implementation of the infection prevention and control program may have lead to further transmission of disease.

Sources: Interviews with staff, and IPAC Lead. Observations. Southbridge Care Homes Policy No: 7.5. "Use of N95 Respirators". Issue Date: December 2021.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control.

Non-compliance with: O. Reg. 246/22 [s. 102 (2) (b) and IPAC Standard – Additional Requirement 10.1]

The licensee shall ensure that the hand hygiene program includes access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR). These agents shall be easily accessible at both point-of care and in other resident and common areas, and any staff providing direct resident care must have immediate access to 70-90% ABHR.

The licensee has failed to ensure that a standard or protocol issued by the Director with respect to

infection prevention and control was implemented.

The licensee has failed to ensure that the Hand Hygiene Program was followed in the IPAC program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard).

Specifically, the licensee did not ensure that the hand hygiene program included access to hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR) as required by Additional Requirement 10.1 under the IPAC Standard.

Rationale and Summary

While conducting a tour of the home, two bottles of ABHR below 70-90% alcohol were found in the third-floor dining room. Another bottle of ABHR below 70-90% alcohol was found on the second floor just outside the second-floor dining room. Additionally, during an observation of an RPN entering a room on enhanced precautions, inspectors observed that the bottle of ABHR on the nursing cart was expired.

In an interview, the Executive Director (ED) verified that the bottles of ABHR identified by the inspectors were below 70-90% alcohol, and that they would be removed immediately.

In an interview, the IPAC Lead stated that bottles of ABHR are to be audited monthly for expiry.

The home's policy titled "Hand Hygiene" Issue Date: April 15, 2022, indicated that "Alcohol-based hand rub must contain 70%-90% isopropyl alcohol."

Failure to ensure access to hand hygiene agents at point-of-care, including 70-90% ABHR may have led to transmission of disease.

Sources: Observations and interviews with the ED and IPAC Lead. Southbridge Care Homes Policy No: 14.2. "Hand Hygiene". Issue Date: April 15, 2022.

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1

A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Non-compliance with: FLTCA, 2021 s. 28(1)1

The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

Rationale and Summary:

A Critical Incident Report (CIR) was submitted to the Director for an allegation of improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.

The incident was not reported to the Ministry action line until the following day.

The homes policy indicated Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident is to be reported to the Director immediately.

Interviews with staff and the Director of Care (DOC) confirmed the Director was not notified immediately notified and agreed that late reporting had occurred as the Director was not informed until the following day.

The impact and risk were moderate when staff did not immediately report the incident to the Director.

Sources: CIR, the homes policy titled “Critical incident Reporting RC-09-01-06- Last review date January 2022, The homes policy titled “Zero Tolerance of Resident Abuse and Neglect: Response and reporting policy- RC-02-01-02- Last review date January 2022, Interviews with staff.

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22 s.40

The licensee shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Non-compliance with: O. Reg 246/22 s.40

The licensee has failed to ensure staff provided resident assistance with safe positioning in bed as specified in the plan of care.

Rationale and Summary:
A CIR was submitted to the Director for an allegation of improper incompetent treatment of a resident which resulted in harm or risk to a resident.

A staff member was providing personal care and repositioning a resident in bed. The resident's medical condition required the use of a therapeutic mattress, the bed had no bedrails. The resident required total assistance for all aspects of bed mobility, and two staff were required for resident safety. The staff member provided care independently, resulting in the resident sliding from the side of the bed to the floor.

Interviews with staff and the DOC confirmed that the staff member was providing care without another staff member present and that resident's plan of care was not followed as two staff were required for bed mobility.

The resident was at risk for injury when staff did not use safe transferring and positioning techniques for bed mobility.

Sources: CIR, resident care plan, interviews with staff and the DOC.