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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: January 11, 2024
Inspection Number: 2023-1147-0003
Inspection Type: Proactive Compliance Inspection
Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)
Long Term Care Home and City: Hope Street Terrace, Port Hope

Lead Inspector	**Inspector Digital Signature**
Julie Dunn (706026)	Julie Dunn Digitally signed by Julie Dunn Date: 2024.01.18 14:44:55 -05'00'

Additional Inspector(s)
Rita Lajoie (741754)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 14, 15, 18, 19, and 20, 2023

The following intake(s) were inspected:

- Intake: #00103629 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Residents' and Family Councils
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Doors in a home

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that doors leading to non-residential areas were kept closed and locked to restrict unsupervised access to those areas by residents.

Rationale and Summary
During a tour of the second floor, it was observed that doors for the north wing tub room and the west wing tub room both had keypad door locks, however both doors were observed to open without using the keypad door locks. The west wing tub

room had a second unlocked door located inside the tub room that led to a laundry chute.

Two personal support worker staff indicated the doors to the tub rooms were always locked and both expressed that they were surprised when the doors opened without using the keypad door locks.

A third staff member and the Administrator both acknowledged the tub room doors should be kept locked.

Subsequently, it was communicated that the keypad on the door for the north wing tub room was repaired, and the keypad on the door for the west wing tub room was replaced. Further observations during the inspection revealed that both tub room doors on the second floor were locked and the west wing tub room had a new keypad door lock.

Failing to ensure that there were working locks on the second floor tub room doors, including the tub room that contained a laundry chute, placed residents at potential risk.

Sources: Observations, interviews with staff and Administrator.
[706026]

WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1.

The licensee failed to ensure that a door in the second-floor resident dining room

and lounge area, a sliding patio door which led to a balcony, was,
i. kept closed and locked,
ii. equipped with a door access control system that is kept on at all times, and
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

Rationale and Summary
During a tour of the long-term care home, a sliding patio door leading to an exterior balcony was observed in a second-floor resident dining room and lounge area. The lever lock mechanism on the door handle was not working. There was no alarm system on the door to detect if the door was opened. Residents used the room as a dining room and as a lounge area, at times unsupervised.

The Administrator acknowledged the requirement for the sliding patio door in the second-floor dining room and lounge area, which led to the balcony, to be equipped with an audible alarm and controlled access locking mechanism and indicated it would be resolved right away.

At the end of the inspection, it was observed that the lever lock on the handle of the sliding patio door leading to the balcony had been repaired. A padlock closure was added to the top right corner of the sliding patio door, which required a key to open. It was communicated that the key to open the padlock would be with the Registered Nurse/Charge Nurse. A laminated sign was posted on the door stating please ensure the door is locked at all times.

A staff member and the Administrator communicated that a door alarm had been

ordered and would be installed on the sliding patio door as soon as it was delivered, with an expected delivery date in January 2024.

Failing to ensure that a door in the second-floor resident dining room and lounge area, which led to a balcony, was kept locked, equipped with a door access control system, and equipped with an audible alarm, potentially put residents at risk.

Sources: Observations, interviews with staff and Administrator.
[706026]

COMPLIANCE ORDER CO #001:

Director of Nursing and Personal Care

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 77 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must:
1) Ensure that the home has a Director of Nursing and Personal Care or a designate that is qualified and has the capacity to fulfill the Director of Nursing and Personal Care's duties at the home at all times.
2) Complete a backup plan, outlining who would be designated as the Director of Nursing and Personal Care, when required.

Grounds
The licensee failed to ensure that the long-term care home had a Director of Nursing and Personal Care (DOC).

Rationale and Summary

The long-term care (LTC) home was operating without a DOC. The Executive Director (ED) communicated that there was no DOC working in the LTC home and confirmed they were aware of the requirement to have a DOC. The ED indicated that the previous DOC left the LTC home in September 2023.

The list of management contacts provided by the ED indicated the position of Director of Care was vacant.

Failing to ensure the LTC home had a Director of Nursing and Personal Care potentially placed the residents at risk, as the Nursing and Personal Care components of the residents' care did not have specific leadership.

Sources: Interview with Executive Director, Management Contacts list. [706026]

This order must be complied with by February 16, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:
(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Ministry of Long-Term Care
Long-Term Care Operations Division
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Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.