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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 22, 2015	2015_346133_0040	O-002674-15	Follow up

Licensee/Titulaire de permis

CVH (No.4) GP Inc. as general partner of CVH (No.4) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Inc. CAMBRIDGE ON N3H 5L8

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

MANOIR MAROCHEL
949 MONTREAL ROAD OTTAWA ON K1K 0S6

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): September 30th, October 1st, October 2nd, 2015

This inspection was in follow up to a Compliance Order related to housekeeping services.

During the course of the inspection, the inspector(s) spoke with the Administrator, the acting Director of Care, the Manager for dietary, housekeeping and laundry services, the RAI coordinator, the Office Manager, registered and non registered nursing staff, a housekeeper, and some residents.

The inspector observed resident bedrooms, bathrooms, items, and areas throughout the home, in order to assess cleanliness. The inspector observed and tested some equipment related to the resident-staff communication and response system.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 VPC(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 15, (2) (a) in that the licensee has failed to ensure that the home is kept clean and sanitary.

The licensee has an ongoing history of non-compliance in this area. As a result of the Resident Quality inspection #2014_198117_0032, conducted in December 2014, a Written Notification was issued. As a result of inspection #2015_346133_0005, conducted in February 2015, the licensee was served with a Compliance Order (#001). As a result of follow up inspection # 2015_346133_0029, conducted in August 2015, the licensee was served with a Compliance Order (#002). This will be the licensee's third consecutive compliance order related to housekeeping.

Inspector #133 conducted a follow up inspection on September 30th – October 2nd, 2015, and a continued trend of non-compliance related cleanliness of walls in resident bathrooms, bedrooms, and some common area, was observed. Other areas of concern were identified, such as cleanliness of some raised toilet seats, call bell cords, bed rails and resident's bathroom storage cupboards. All areas of concern were first observed on September 30th, 2015, and all were observed again on October 2nd, 2015. Few improvements were noted, despite the daily cleaning program in place, and were limited to some of the areas observed and discussed by the inspector, administrator, and the designated lead for the housekeeping services program, on October 1st, 2015.

As per discussion with the Administrator throughout the inspection, it is noted that the home continues to experience ongoing staffing challenges within the housekeeping program. The Administrator informed that as of October 9th, 2015, there would be an extra hour added to the housekeeping shifts, and that two new part time positions would be created. As well, the Administrator explained that deep cleaning of one bedroom would be scheduled for every other day.

Areas of observed concern were almost exclusively located within the west hallway and were as follows:

West dining room – The following observations were made as of 10:30am on September 30th, 2015. At the window closest to the kitchen, the wall to the left and the baseboard beneath was dirty with dried food debris. It is noted that the plate cleaning trolley is located in this area during meal service. This had been previously identified as an area of concern by inspector #133 (inspection #2015_346133_0029). Near resident #005 's

table, it was observed that the wall was dirty with areas of dried light colored matter. This has been previously identified as an area of concern by inspector #133 (Inspection 2015_346133_0029). The floor throughout the dining room was dirty with stains and dried food matter and sticky residue. Dried green matter was observed on the floor near the table closest to the dining room servery. The inspector asked the cook in the kitchen, staff # S106, if there had been anything green served for breakfast and the cook indicated that nothing green had been prepared for the breakfast meal. Within the outer servery, it was observed that the microwave was dirty with heavy accumulation of dried food matter and the counter beneath the microwave was also dirty with heavy accumulation of debris.

On October 2nd, the inspector and the dietary manager, who is the newly designated lead for the housekeeping services program, observed that the walls and the microwave, as described above, had not been cleaned.

Hallway outside of bedroom #101 and the dining room - The lower wall outside of the dining room was dirty with spots and streaks of brown matter. The lower wall outside of bedroom #101, to the left, was dirty with an area of dried red matter, some dried pink streaks and spots of light brown matter.

Hallway - The light fixture outside of bedroom #127 and #129 was dirty with accumulated dead insects. This had been previously identified by inspector #133 (inspection # 2015_346133_0029).

Bedroom #A – In the bathroom, the wall next to the toilet was dirty with spots of light brown to clear matter, and some brown spots around the handrail. The lower wall across from the toilet was dirty with light brown and dark brown matter, as was the baseboard. The wall under the sink was dirty with spots of brown matter and the baseboard was dirty with some dark brown matter.

In the bathroom, hanging on one of the towel bars, there was a cloth bag that contained garbage bags. It was ascertained that such bags are provided by the home, in place to ensure a supply of garbage bags. The bag was pink with flowers on it. The bag was dirty with dried brown matter and yellow matter throughout.

Bedroom #B – The ceiling above resident #006's bed was dirty with an area of dried brown matter, close to the sprinkler head, and areas of bits of yellowish material. This had been previously identified by inspector #133 (inspection # 2015_346133_0029).

In the washroom, the wall behind the toilet, to the right, was dirty with streaks of light brown and a thick string of matter that appeared to be dust. The lower wall next to the garbage was dirty with spots of dried dark matter and there was accumulated white powder in the corner/on the baseboard behind the garbage.

Bedroom #C – In the bathroom, the wall under the counter was dirty with brown spots throughout.

Bedroom #D – In the bathroom, the wall behind the toilet, to the left, was dirty throughout with spots of brown matter.

West tub room – The side of the privacy curtain facing the door was dirty with brown spots along the length of the lower portion, most pronounced in the lower right area. The wall to the right of the privacy curtain was dirty with spots of brown matter, as was the lower wall to the left of the privacy curtain. The lower wall, upon entry, left side, was dirty with spots of brown matter throughout.

The light fixture above the tub was dirty with accumulation of dead inspects. This had been previously identified by inspector #133 (inspection #2015_346133_0029).

Bedroom #E – In the bathroom, there was a bubble style raised seat, with arms, in place on the toilet. The toilet seat was odorous and beneath it there was an accumulation of brown matter and metallic debris, which appeared to be corrosion from the screws in the base of the seat. This had been previously identified by inspector #133 (inspection #2015_346133_0029).

In the bathroom, the wall behind the toilet was dirty with spots of brown matter. The wall next to the toilet was dirty with spots of dried dark matter. The wall across from the toilet was dirty with spots of dried brown matter. The wall above the garbage and around it was dirty with dried brown matter. The wall under the mirror was dirty with a streak of brown matter.

The outer door of both resident's storage cupboards in the bathroom, and the shelf below, was dirty with residue and dried matter.

Bedroom #F – The wall under the alcohol dispenser was dirty with spots of dried brown matter throughout. The wall to the left, upon entry, under the mirror, and including the

baseboard, was dirty with spots of dried brown matter. The wall behind the bed, to the left, was dirty with an elongated area of dried brown matter. The side of the bedside table, next to the garbage can, was dirty with pieces of dried matter.

The bed rails were dirty with dried matter, most pronounced on the left side.

The bedside call bell cord was dirty with accumulated dark sticky matter.

In the bathroom, the wall behind the toilet, to the left, was dirty with spots of dried brown matter. The outer front area of the toilet bowl was dirty with areas of dried dark matter.

In the bathroom, on the raised toilet seat with legs, there was dried brown matter on the rail near the left hand grip, on the bar under the seat, on the right leg, on the underside of the perpendicular rails under the seat.

In the bathroom, on the towel bar, there was a beige cloth bag that contained garbage bags. These cloth bags are put in place by the home. The bag was dirty with spots of dried matter and yellow stains throughout.

Bedroom #G – The wall to the right of the window, and under the lower right corner of the window, was dirty with five distinct areas of dried light coloured matter.

Bedroom #H – In the bathroom, there was a bubble seat in place on the toilet. Between the seat and the toilet bowl rim, towards the front, and at the left side, there was accumulation of brown matter.

The left bed rail was dirty with sticky light coloured matter and some dried brown matter.

Bedroom #I – The lower wall upon entry, under the alcohol hand rub dispenser, was dirty with light brown spots throughout.

Bedroom #J – In the bathroom, the wall next to the toilet was dirty with small spots of dried dark matter as was the wall next to the sink. The wall above the towel bar closest to the door leading into #J was dirty with accumulation of dried beige/yellow matter. This matter could be scraped off with a fingernail. This had been previously identified by inspector #133 (inspection #2015_346133_0029). The inner bathroom door, leading to the other bedroom, was dirty with a small streak of dried brown matter and some spots of brown matter.

The bathroom door frame, in the area of the striker plate, was dirty with an area of dried brown matter.

The wall to the left of the bathroom door was dirty with small brown and orange spots.

Bedroom #K – The wall behind and to the right of the bed was dirty with spots of dried matter of various colors.

In the bathroom, the wall at the grab bar was dirty with some dried red matter, and some brown matter, above the toilet paper. The wall behind the toilet, to the left, was dirty with areas of dried brown matter as was the outer side of the counter stand.

Bathroom #L/#M – On September 30th and October 1st, 2015, there was a strong lingering odor of urine in this bathroom, despite routine cleaning. This bathroom had been identified as problematic in past inspections, related to lingering urine odor (#2015_346133_0029, #2014_198117_0032). On the evening of October 1st, 2015, inspector #133 spoke with a member of the housekeeping program, #S107, who was currently working as a laundry aide, about this bathroom. The inspector asked if this bathroom was ever free of lingering urine odor. Staff #S107 told the inspector that they were assigned to work as a laundry aid on October 2nd, but that they would personally clean the bathroom, very thoroughly, for 9:30am, so the inspector could observe if the urine odor lingered despite a thorough cleaning. On October 2nd, at 10:15am, the inspector confirmed that the bathroom had been cleaned by staff #S107, and it was observed that there was no lingering urine odor. The inspector returned to the bathroom throughout the day, and there was no lingering urine odor.

Bedroom #N – The bedside call bell cord was very dirty with accumulation of dried brown matter.

Bedroom #O – In the bathroom, the wall next to the toilet and the lower bathroom door leading into the other bedroom was dirty with brown spots. The lower wall under the towel bar closest to the door leading into bedroom #O was dirty with spots of brown matter.

Bedroom #P – In the bathroom, the wall next to the toilet was dirty with spots of dried brown matter, most pronounced around the toilet paper dispenser. The lower bathroom door leading into bedroom #P was dirty with brown spots. The wall behind the toilet, to

the right, was dirty with spots of brown matter.

Bedroom #Q – In the bathroom, the outer door of both resident's storage cupboards, the shelves below, and the wall space in between, was dirty with accumulated residue of various colours.

In the bathroom, the outer upper toilet bowl was dirty with brown matter in several areas. The wall around the toilet paper was dirty with streaks of brown matter. The underside of the lower grab bar next to the toilet was dirty with dried brown matter.

West nursing station – The walls were dirty throughout with light brown spots and streaks, and darkened areas. This was previously identified by inspector #133 (inspection #2015_346133_0029).

South hallway:

Bedroom #R – In the bathroom, there was a light blue cloth bag with orange flowers, that contained garbage bags. It was dirty with two areas of dried brown matter.

Hallway - The light fixture outside of room #118 and #120 was dirty with an accumulation of dead insects. This was previously identified by inspector #133 (inspection #2015_346133_0029). [s. 15. (2) (a)]

2. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c) in that the licensee has failed to ensure that the home, furnishings and equipment are maintained in safe condition and in a good state of repair.

Note that the licensee was served with a Compliance Order (CO), #001, pursuant LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (c) on August 24th, 2015 as a result of inspection 2015_346133_0029. Full compliance for this CO is due on August 22, 2016, with a requirement to submit interim progress reports by November 30th, 2015 and April 4th, 2016. Therefore, the evidence presented below is additional information for Compliance Order #001, and must be addressed in the written progress report due by November 30th, 2015.

The following non-compliance is related to equipment associated with the resident-staff communication and response system (the system). In resident #001's bedroom, the bedside activation cord was not functioning consistently and the activation cord for the

bathroom console was missing. The group 4 pager was not functional. In resident #002's bedroom, the bedside activation cord had been cut or torn apart. In resident #003's bedroom, the bedside activation cord was in very poor repair and could not be used to make a call for assistance.

On October 2nd, 2015, at 11:30am, inspector #133 attempted to make a call for assistance on behalf of resident #001 from his/her bedroom, first by using the bedside system activation cord. The red button at the end of the activation cord was pressed, and the dome light outside of the resident's bedroom did not illuminate. The inspector attempted this several times, and each time the dome light outside of the bedroom failed to illuminate. The inspector then went into the resident's bathroom, and noted that the activation cord was missing from the system wall console, next to the toilet. The inspector pushed the small black console button downwards, which did result in the illumination of the dome light. While attending to resident #001s needs in his/her bedroom, Personal Support Worker (PSW) #S100 told the inspector that resident #001s bedside activation cord sometimes works and sometimes doesn't work to illuminate the dome light. The PSW did not have her assigned pager at the time, and it could not be confirmed if the problem was with the system or with the dome light. The PSW and the inspector proceeded to the South nurses' station. It was observed that on the system console on the wall in the nurses' station, the light corresponding to resident #001s bedroom was flashing. It was concluded that problem appeared to be associated with the dome light outside of resident #001's bedroom. PSW #S100 picked up her assigned pager (group 4) from a basket on the desk, and noted that it was not functional. A change of batteries, by the RAI coordinator, did not fix the pager, and it was confirmed that there were no replacement pagers available in the home for the PSW to use (see WN #2 for further information). The inspector asked PSW #S100 if there were any other bedrooms where there were concerns about the system, and the PSW directed the inspector to resident #002's bedroom.

On October 2nd, 2015, at 12:00pm, inspector #133 proceeded to resident #002's bedroom, in the company of PSW #S103. It was observed that the resident's bedside system activation cord appeared to have been cut or torn, and only the knob remained in place in the wall console. The PSW informed the inspector that the cord had been in this condition for weeks. The inspector spoke with the Office Manager, who explained that she had been made aware of this issue, by the RAI coordinator, on September 25th, 2015, and that she had called the company, Mircom, for a replacement cord on September 29th, 2015. The Office Manager explained that a company representative had confirmed that they had replacement cords in stock, but they were closed for

inventory that week. The Office Manager indicated she would be picking up a new cord for resident #002's bedroom on Monday, October 5th, 2015.

On October 2nd, 2015, at 2:46pm, inspector #133 spoke with a PSW in the West hall, #S104, about the system, and asked if they were aware of any bedrooms in which the system was not functional. The PSW directed the inspector to resident #003's bedroom. The inspector went to the bedroom and observed the bedside system activation cord to be in very poor repair. The inspector observed white tape over bare wires on a section just before the end knob, and the red activation button at the end was recessed within the end knob. A call for assistance could not be made using this cord. Resident #003 came out of the bathroom while the inspector was testing the cord, and he/she exclaimed "that thing doesn't work".

On October 2nd, 2015, at 3:30pm, inspector #133 returned to resident #001's bedroom, to test the resident's bedside system activation cord again. On this occasion, pressing the red button did result in the illumination of the dome light outside of the resident's bedroom. This served to validate PSW #S100's earlier comment about the reliability of the resident's bedside system activation cord.

The inspector informed the Administrator of the above observations as they occurred. The Administrator, who is serving as the designated lead of the maintenance program in the absence of the Environmental Manager, informed the inspector that he had not been made previously aware of these issues and that he would follow up. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 44 in that the licensee has

failed to ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of the residents.

This is specifically related to the availability of pagers for nursing staff, which are connected to the resident-staff communication and response system (the system), and which directly notify nursing staff when a call for assistance has been made.

On October 2nd, 2015, at 11:30am, inspector #133 noted that resident #001 was sitting in their wheelchair, in their bedroom doorway, and there appeared to be blood on the resident's hands. Inspector #133 entered the resident's bedroom and attempted to make a call for assistance by using the system activation cord at the resident's bedside, as there was no nursing staff visible to the inspector in the area. The bedside system activation cord failed to illuminate the dome light outside of the resident's bedroom, on multiple attempts, which suggested that a call for assistance had not been made through to the system. The inspector then entered the resident's washroom and activated the system console on the wall next to the toilet, which did result in the illumination of the dome light outside of the resident's bedroom. A Personal Support Worker (PSW), #S100, who was at the end of the West hallway, noticed the inspector going in and out of the resident's bedroom, and came to inquire if assistance was needed. The inspector asked the PSW if the call for assistance from resident #001's washroom had registered on her pager. The PSW told the inspector that she was not in possession of her pager. After the PSW, #S100, assisted the resident, the inspector accompanied her to the South nurses' station, to pick up her assigned pager. The PSW picked up her pager (group 4) from a basket on the desk and showed the inspector that it was not working. The PSW gave her pager to the RAI Coordinator, #S101, so that he could change the batteries. The inspector and PSW #S100 then sought out her partner PSW, #S102, in attempt to find a functional pager to further test the system in resident #001's bedroom. The partner PSW, S#102, explained that he did not have a pager, as his (group 5) was missing. The PSW, #S102, explained that the group 5 pager had been missing for some time. The PSW, #S102, elaborated that he had started his work week on Tuesday, September 29th, 2015, and the group 5 pager had been missing since then. He explained that during his previous work week, he had used other pagers and he could not recall if the group 5 pager had been available. Inspector #133 then met with the RAI coordinator, #S101, who informed that he had changed the batteries in the group 4 pager, but that it was still not working. The RAI coordinator confirmed to the inspector that it was known that the group 5 pager was missing, but he was not able to recall how long it had been missing for. The RAI coordinator confirmed that there were no extra pagers available to provide to PSWs #S100 and #S102. The RAI coordinator confirmed that there should be a functional

pager for every PSW, and informed that he believed that there was another pager missing. The inspector sought out the two other PSWs working in the West hall, who were also partnered, and it was determined that they both had a functional pager. The RAI coordinator confirmed that the four PSWs working in the South hall were each in possession of a functional pager.

Two of eight pagers, which are connected to the resident-staff communication and response system, and which directly notify nursing staff when a call for assistance has been made, were not available for use by nursing staff at the time of the inspection. [s. 44.]

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 with the requirement that equipment required to meet the nursing and personal care needs of residents is readily available in the home, specific to pagers used by nursing staff that are connected to the resident-staff communication and response system, which notify nursing staff directly when a call for assistance is made,, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 87 (1) (d) in that the licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odors.

On September 30th, October 1st and October 2nd, 2015, throughout the inspection days, the inspector noted a lingering urine odor in bathroom #S. This odor remained despite daily cleaning of the bathroom. This was discussed with the Administrator, on October 2nd, who informed that he had not been made aware that this was a problematic bathroom, and that he would ensure that procedures were implemented for addressing the lingering offensive odor.

The licensee has a history of non-compliance related to lingering offensive odors. As a result of the 2014 Resident Quality Inspection, 2014_198117_0032, conducted in December 2014, a written notification was issued. As a result of inspection #2015_346133_0029, conducted in August 2015, a written notification with the additional required action of a voluntary plan of correction was issued. [s. 87. (2) (d)]

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 with the requirement that procedures are developed and implemented for addressing incidents of lingering offensive odors, specific to bathroom #S,, to be implemented voluntarily.

WN #4: 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 comply with O. Reg. 79/10, s. 229 (4) in that the licensee has failed to ensure that all staff participate in the implementation of the infection

prevention and control program.

On September 30th, 2015, over the course of the inspection day, the following was observed, related to improper storage of urine collection hats (UCHs) within resident bathrooms. UCHs are to be discarded after use, and are to be stored in a clean environment until ready for use.

Bedroom #111 – In the bathroom, there was a large white margarine pail next to the toilet. There were three UCHs within the pail, two were together facing a third. The single UHC was dirty with dried yellow and brown matter inside and out. Of the two that were together, the inner one was dirty with yellow and dark matter inside, the outer one was dirty with a few brown spots outside and dried yellow brown matter outside

Bedroom #137 - In the bathroom, on the towel bar next to the sink, there was a single UCH. The outer base was dirty with a brownish/beige film that could be scraped off, as was the rim, and there were small specks of brown matter around the rim.

Bedroom #135 – In the bathroom, on the floor under the counter, there was a stack of plastic items, including UCHs. At the base of the stack there was a pink wash basin and a blue washbasin. On top of the washbasins, there were three UCHs. The bottom one was dirty with a sm area of brown matter, the second one was dusty with brown spots, and the third was dirty with accumulated dust. On top of the UCHs, there was a blue washbasin that was dirty on the outside with some dried brown matter and debris. Inside that blue washbasin, there was a blue care caddy, labelled with resident #004's name, that was very dirty with residue and white matter.

Storage of such items on the floor, which is an inherently contaminated surface, is not in line with good infection prevention and control practices.

Bedroom #100 – In the bathroom, there were two UCHs stored together on the grab bar above the toilet. The top UCH was dirty with spots of dried yellow matter on the rim and inside.

Bedroom #140 – In the bathroom, there was a UCH on the grab bar above the toilet.

Bedroom #134 – In the bathroom, there were two separate UCHs on the grab bar above the toilet. The left UCH was dirty with hair and dust inside, the UCH on the right was dirty outside with spots of dried yellow matter.

Bedroom #110 – In the bathroom, there were two UCHs stored together on the grab bar above the toilet. The bottom one was dirty with dried brown matter around the outer rim and the top one was dirty on the underside of the rim with dried brown matter.

Bedroom #124 – In the bathroom, there was one UCH on the grab bar above the toilet. It was dirty with dried yellow residue.

Bedroom #120 –In the bathroom, on top of the cupboard, there was a stack of five UCHs. The top one was dirty with spots of dried yellow matter.

Bedroom #122 – In the bathroom, there was one UCH on the grab bar above the toilet that was dirty with hair and dust inside. Also, there was a pink bed pan on the grab bar, labelled "5th floor", that was dirty outside with accumulated dust.

On September 30th, 2015, at 5pm, the inspector met with the acting Director of Care (aDOC), who identified herself as the designated lead for the infection prevention and control program. The aDOC confirmed that staff are to dispose of UCHs after use, and that clean UCHs are not to be stored in the resident washrooms, due to the likelihood of contamination. The aDOC explained that there are UCHs in storage in the South hallway, which are always accessible to staff. The aDOC was shown a picture of the stack of plastic wear on the bathroom floor in bedroom #135, and agreed that storage of such items on the floor was not appropriate. The aDOC and the inspector went together to bedroom #111 and the aDOC removed the pail next to the toilet that contained the three UCHs. The aDOC indicated she would have staff working on modified duty go bedroom to bedroom and remove all of the UCHs.

The licensee has a history of non compliance in this area. As a result of the 2014 Resident Quality Inspection, 2014_198117_0032, conducted in December 2014, a written notification, with the additional required action of a voluntary plan of correction, was issued. [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 with the requirement that nursing staff participate in the implementation of the infection prevention and control program, specifically related to the storage and disposal of urine collection hats,, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Specifically failed to comply with the following:

s. 92. (2) The designated lead must have,
(a) a post-secondary degree or diploma; O. Reg. 79/10, s. 92 (2).
(b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and O. Reg. 79/10, s. 92 (2).
(c) a minimum of two years experience in a managerial or supervisory capacity. O. Reg. 79/10, s. 92 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 92 (2) (b) in that the licensee has failed to ensure that the designated lead for the housekeeping and laundry services program has knowledge of evidence-based practices relating to housekeeping and laundry.

On September 30th, 2015, the Administrator identified that the Dietary Manager, staff #S108, was now the manager for the housekeeping and laundry services program. On October 2nd, 2015, inspector #133 met with staff #S108, who identified herself as the new manager for the housekeeping and laundry services programs. The inspector asked staff #S108 if she had knowledge of evidence-based practices relating to housekeeping and laundry. Staff #S108 replied that she was not aware of any evidence-based practices relating to housekeeping and laundry, and asked the inspector for an example of such. Staff #S108 explained that she had no background in housekeeping and laundry services, but that she knew the home and the staff very well. Staff #S108 informed that she was awaiting training from an Extendicare Assist representative, and in the meantime she was trying to work with the Administrator to learn what to do. [s. 92. (2)]

Issued on this 22nd day of October, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2015_346133_0040
Log No. / Registre no:	O-002674-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 22, 2015
Licensee / Titulaire de permis :	CVH (No.4) GP Inc. as general partner of CVH (No.4) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes Inc., CAMBRIDGE, ON, N3H-5L8
LTC Home / Foyer de SLD :	MANOIR MAROCHEL 949 MONTREAL ROAD, OTTAWA, ON, K1K-0S6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bipin Raut

To CVH (No.4) GP Inc. as general partner of CVH (No.4) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_346133_0029, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,

(a) the home, furnishings and equipment are kept clean and sanitary;

(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and

(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee will prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, S.O. 2007, c. 8, s. 15 (2) (a). The licensee must ensure that the home, furnishings and equipment are kept clean and sanitary.

The plan must include detailed and comprehensive strategies that will ensure that the daily housekeeping routines in place address offensive odors and accumulated dried matter on surfaces, equipment and furnishings.

The plan must address the ongoing staffing challenges within the housekeeping services program, and outline how the licensee will ensure that the home, furnishings and equipment will be kept clean and sanitary despite this. There is to be a daily monitoring process to detect and address issues, while the housekeeping program is being rebuilt and until such time that stability is achieved.

The plan must provide for on-site training and ongoing mentoring of the designated lead for the housekeeping program by a person with previous experience in the area of housekeeping program management and knowledge of evidenced based practices relating to housekeeping.

The compliance plan is due on Friday, October 30th, 2015. The plan may be emailed to inspector #133's (Jessica Lapensée) attention at the following email address: OttawaSAO.MOH@ontario.ca. Alternately, the compliance plan may be faxed to the inspector's attention at (613) 569-9670 or mailed to 347 Preston Street, Suite 420, 4th floor, Ottawa, Ontario, K1S 3J4.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 15, (2) (a) in that the licensee has failed to ensure that the home is kept clean and sanitary.

The licensee has an ongoing history of non-compliance in this area. As a result of the Resident Quality inspection #2014_198117_0032, conducted in December 2014, a Written Notification was issued. As a result of inspection #2015_346133_0005, conducted in February 2015, the licensee was served with a Compliance Order (#001). As a result of follow up inspection # 2015_346133_0029, conducted in August 2015, the licensee was served with a Compliance Order (#002). This will be the licensee's third consecutive compliance order related to housekeeping.

Inspector #133 conducted a follow up inspection on September 30th – October 2nd, 2015, and a continued trend of non-compliance related cleanliness of walls in resident bathrooms, bedrooms, and some common area, was observed. Other areas of concern were identified, such as cleanliness of some raised toilet seats, call bell cords, bed rails and resident's bathroom storage cupboards. All areas of concern were first observed on September 30th, 2015, and all were observed again on October 2nd, 2015. Few improvements were noted, despite the daily cleaning program in place, and were limited to some of the areas observed and discussed by the inspector, administrator, and the designated lead for the housekeeping services program, on October 1st, 2015.

As per discussion with the Administrator throughout the inspection, it is noted that the home continues to experience ongoing staffing challenges within the housekeeping program. The Administrator informed that as of October 9th, 2015, there would be an extra hour added to the housekeeping shifts, and that two new part time positions would be created. As well, the Administrator explained that deep cleaning of one bedroom would be scheduled for every other day.

Areas of observed concern were almost exclusively located within the west hallway and were as follows:

West dining room – The following observations were made as of 10:30am on September 30th, 2015. At the window closest to the kitchen, the wall to the left and the baseboard beneath was dirty with dried food debris. It is noted that the plate cleaning trolley is located in this area during meal service. This had been previously identified as an area of concern by inspector #133 (inspection #2015_346133_0029). Near resident #005 's table, it was observed that the wall was dirty with areas of dried light colored matter. This has been previously identified as an area of concern by inspector #133 (Inspection 2015_346133_0029). The floor throughout the dining room was dirty with stains and dried food matter and sticky residue. Dried green matter was observed on the floor near the table closest to the dining room servery. The inspector asked the cook in the kitchen, staff # S106, if there had been anything green served for breakfast and the cook indicated that nothing green had been prepared for the breakfast meal. Within the outer servery, it was observed that the microwave was dirty with heavy accumulation of dried food matter and the counter beneath the microwave was also dirty with heavy accumulation of debris.

On October 2nd, the inspector and the dietary manager, who is the newly designated lead for the housekeeping services program, observed that the walls and the microwave, as described above, had not been cleaned.

Hallway outside of bedroom #101 and the dining room - The lower wall outside of the dining room was dirty with spots and streaks of brown matter. The lower wall outside of bedroom #101, to the left, was dirty with an area of dried red matter, some dried pink streaks and spots of light brown matter.

Hallway - The light fixture outside of bedroom #127 and #129 was dirty with accumulated dead insects. This had been previously identified by inspector #133 (inspection # 2015_346133_0029).

Bedroom #A – In the bathroom, the wall next to the toilet was dirty with spots of light brown to clear matter, and some brown spots around the handrail. The lower wall across from the toilet was dirty with light brown and dark brown matter, as was the baseboard. The wall under the sink was dirty with spots of brown matter and the baseboard was dirty with some dark brown matter.

In the bathroom, hanging on one of the towel bars, there was a cloth bag that contained garbage bags. It was ascertained that such bags are provided by the home, in place to ensure a supply of garbage bags. The bag was pink with flowers on it. The bag was dirty with dried brown matter and yellow matter throughout.

Bedroom #B – The ceiling above resident #006's bed was dirty with an area of dried brown matter, close to the sprinkler head, and areas of bits of yellowish material. This had been previously identified by inspector #133 (inspection # 2015_346133_0029).

In the washroom, the wall behind the toilet, to the right, was dirty with streaks of light brown and a thick string of matter that appeared to be dust. The lower wall next to the garbage was dirty with spots of dried dark matter and there was accumulated white powder in the corner/on the baseboard behind the garbage.

Bedroom #C – In the bathroom, the wall under the counter was dirty with brown spots throughout.

Bedroom #D – In the bathroom, the wall behind the toilet, to the left, was dirty throughout with spots of brown matter.

West tub room – The side of the privacy curtain facing the door was dirty with brown spots along the length of the lower portion, most pronounced in the lower right area. The wall to the right of the privacy curtain was dirty with spots of brown matter, as was the lower wall to the left of the privacy curtain. The lower wall, upon entry, left side, was dirty with spots of brown matter throughout.

The light fixture above the tub was dirty with accumulation of dead inspects. This had been previously identified by inspector #133 (inspection #2015_346133_0029).

Bedroom #E – In the bathroom, there was a bubble style raised seat, with arms, in place on the toilet. The toilet seat was odorous and beneath it there was an accumulation of brown matter and metallic debris, which appeared to be corrosion from the screws in the base of the seat. This had been previously identified by inspector #133 (inspection #2015_346133_0029).

In the bathroom, the wall behind the toilet was dirty with spots of brown matter. The wall next to the toilet was dirty with spots of dried dark matter. The wall across from the toilet was dirty with spots of dried brown matter. The wall above the garbage and around it was dirty with dried brown matter. The wall under the mirror was dirty with a streak of brown matter.

The outer door of both resident's storage cupboards in the bathroom, and the shelf below, was dirty with residue and dried matter.

Bedroom #F – The wall under the alcohol dispenser was dirty with spots of dried brown matter throughout. The wall to the left, upon entry, under the mirror, and including the baseboard, was dirty with spots of dried brown matter. The wall behind the bed, to the left, was dirty with an elongated area of dried brown matter. The side of the bedside table, next to the garbage can, was dirty with pieces of dried matter.

The bed rails were dirty with dried matter, most pronounced on the left side.

The bedside call bell cord was dirty with accumulated dark sticky matter.

In the bathroom, the wall behind the toilet, to the left, was dirty with spots of dried brown matter. The outer front area of the toilet bowl was dirty with areas of dried dark matter.

In the bathroom, on the raised toilet seat with legs, there was dried brown matter on the rail near the left hand grip, on the bar under the seat, on the right leg, on the underside of the perpendicular rails under the seat.

In the bathroom, on the towel bar, there was a beige cloth bag that contained garbage bags. These cloth bags are put in place by the home. The bag was dirty with spots of dried matter and yellow stains throughout.

Bedroom #G – The wall to the right of the window, and under the lower right corner of the window, was dirty with five distinct areas of dried light coloured matter. As previously identified, resident #005 is known to spit a lot.

Bedroom #H – In the bathroom, there was a bubble seat in place on the toilet. Between the seat and the toilet bowl rim, towards the front, and at the left side, there was accumulation of brown matter.

The left bed rail was dirty with sticky light coloured matter and some dried brown matter.

Bedroom #I – The lower wall upon entry, under the alcohol hand rub dispenser, was dirty with light brown spots throughout.

Bedroom #J – In the bathroom, the wall next to the toilet was dirty with small spots of dried dark matter as was the wall next to the sink. The wall above the towel bar closest to the door leading into #J was dirty with accumulation of dried beige/yellow matter. This matter could be scraped off with a fingernail. This had been previously identified by inspector #133 (inspection #2015_346133_0029). The inner bathroom door, leading to the other bedroom, was dirty with a small streak of dried brown matter and some spots of brown matter.

The bathroom door frame, in the area of the striker plate, was dirty with an area of dried brown matter.

The wall to the left of the bathroom door was dirty with small brown and orange spots.

Bedroom #K – The wall behind and to the right of the bed was dirty with spots of dried matter of various colors.

In the bathroom, the wall at the grab bar was dirty with some dried red matter, and some brown matter, above the toilet paper. The wall behind the toilet, to the left, was dirty with areas of dried brown matter as was the outer side of the counter stand.

Bathroom #L/#M – On September 30th and October 1st, 2015, there was a strong lingering odor of urine in this bathroom, despite routine cleaning. This bathroom had been identified as problematic in past inspections, related to lingering urine odor (#2015_346133_0029, #2014_198117_0032). On the evening of October 1st, 2015, inspector #133 spoke with a member of the housekeeping program, #S107, who was currently working as a laundry aide, about this bathroom. The inspector asked if this bathroom was ever free of lingering urine odor. Staff #S107 told the inspector that they were assigned to work as a laundry aid on October 2nd, but that they would personally clean the bathroom, very thoroughly, for 9:30am, so the inspector could observe if the urine odor lingered despite a thorough cleaning. On October 2nd, at 10:15am, the inspector confirmed that the bathroom had been cleaned by staff #S107, and it was observed that there was no lingering urine odor. The inspector returned to the bathroom throughout the day, and there was no lingering urine odor.

Bedroom #N – The bedside call bell cord was very dirty with accumulation of dried brown matter.

Bedroom #O – In the bathroom, the wall next to the toilet and the lower bathroom door leading into bedroom #O was dirty with brown spots. The lower wall under the towel bar closest to the door leading into the other bedroom was dirty with spots of brown matter.

Bedroom #P – In the bathroom, the wall next to the toilet was dirty with spots of dried brown matter, most pronounced around the toilet paper dispenser. The lower bathroom door leading into bedroom #137 was dirty with brown spots. The wall behind the toilet, to the right, was dirty with spots of brown matter.

Bedroom #Q – In the bathroom, the outer door of both resident's storage cupboards, the shelves below, and the wall space in between, was dirty with

accumulated residue of various colours.

In the bathroom, the outer upper toilet bowl was dirty with brown matter in several areas. The wall around the toilet paper was dirty with streaks of brown matter. The underside of the lower grab bar next to the toilet was dirty with dried brown matter.

West nursing station – The walls were dirty throughout with light brown spots and streaks, and darkened areas. This was previously identified by inspector #133 (inspection #2015_346133_0029).

South hallway:

Bedroom #R – In the bathroom, there was a light blue cloth bag with orange flowers, that contained garbage bags. It was dirty with two areas of dried brown matter.

Hallway - The light fixture outside of room #118 and #120 was dirty with an accumulation of dead insects. This was previously identified by inspector #133 (inspection #2015_346133_0029). (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 14, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 22nd day of October, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JESSICA LAPENSEE

Service Area Office /
Bureau régional de services : Ottawa Service Area Office