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
Nov 20, 2017	2017_621547_0013	008654-17, 014116-17, 021724-17, 022468-17	Critical Incident System

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

LISA KLUKE (547)

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): September 19, 20, 21, 22, 25, 26, 29, October 3, 2017

This inspection was related to two critical incidents the home submitted and two complaints related to care and services by the home.

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the home's Resident Assessment Instrument (RAI) Coordinator, the Office Manager, a staffing clerk, the Nutritional Manager, the Extendicare Assist LTC nursing consultant and the Administrator.

In addition, over the course of the inspection, the inspector reviewed residents' health care records, staff work routines, observed resident rooms, resident common areas, reviewed policies related to complaints, continence and specified education reports. The inspector observed the delivery of resident care and services and staff to resident and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written procedures in the home for complaints was not complied with.

The following finding relates to three specified complaints:

As required with O. Reg 79/10, s.100 the licensee shall ensure that written procedures required as per the Long-Term care homes Act, 2007 S.O.2007, c.8, s. 21 that incorporate the requirements set out in section 101 of O. Reg 79/10 with regards to dealing with complaints.

On September 29, 2017 the Administrator provided Inspector #547 the current policy and procedure titled Complaints and Customer Service # RC-09-01-04 last revised April 2017.

This policy and procedure stated that "Management and resolution of issues will ensure that residents, families, SDMs and other stakeholders receive a response within required legislative time frames and the addressed concerns are documented. An Investigation is initiated into the circumstances leading to the complaint utilizing the appendices 1-5 inclusively for this process" documented records of investigations on:

-Complaint Investigation Form Appendix 1- to be completed in detail if a complaint cannot be resolved within 24 hours and forwarded to the Administrator,

-Investigation observation form Appendix 2- to describe any observations made during the investigation,

-Investigation interview form Appendix 3- to record details of interviews performed,

-Investigation contact form Appendix 4- to document the date, time, the person contacted, and reason of each contact with the complainant,

-Complaint log Appendix 5- to maintain a record of all complaints and actions taken in the home

The Licensee's failed to comply with the policy and procedure for managing complaints received by the home on two specified dates in 2017, that deal with the requirements set

out in O.Reg 79/10 s.101 as follows:

1. There was no documentation of any investigation to indicate what actions were done by the home for these ongoing complaints regarding continence care and infection control practices,

2. There was no observations documented of any staff performing continence care, or observations of infection control practices of changing of soiled briefs,

3. There was no documentation of staff interviews to these issues related to care and services,

4. There was no written response to the complainant regarding the resolution and response for the issues related to care and services from the complainant,

5. These complaints were not added to the home's complaint log to identify the requirement to analyze for trends at least quarterly, the results of the review and analysis and what improvements.

The Administrator indicated to Inspector #547 on September 29, 2017 that they had not followed the Licensee's policy or the appendices 1-5 procedures regarding written complaints in the home. The Administrator further indicated that the home would need to review the Licensee's policy and procedure and ensure that it is complied as required by this section. [s. 8. (1) (b)]

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 the home complies with the Licensee's most up to date complaints policy and procedure, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure to immediately forward any written complaints that have been received concerning the care of a resident or the operation of the home to the Director.

Inspector #547 spoke to resident #001's SDM on a specified date regarding a complaint made to the Director regarding care and services related to continence care, infection control practices as well as issues related to changes to the resident's plan of care without the SDM's consent. The resident's SDM indicated to be frustrated with the home, as the SDM had made the same complaint almost every month for several specified months, with no response by the home's management. The SDM did not see any attempts by the home's management to address concerns brought forward. The SDM forwarded the Inspector a written complaint made to the home on two specified dates, that were addressed to the Administrator. These written complaints identified concerns related to continence care and infection control practices regarding changing of soiled briefs process in the home as an ongoing concern for resident #001's SDM.

On October 3, 2017 the Administrator indicated to Inspector #547 that he forwarded a critical incident report on a specified date for the written complaint he received on another specified date two days earlier. The Administrator indicated that he forwarded another critical incident report on a specified date for the complaint received four days earlier. The Administrator further indicated to Inspector #547 to have received another written complaint from resident #001's SDM on a specified date recently, however he has not forwarded this to the Director to date, as they are all indicating the same issues. The Administrator indicated that written complaints related to care and operations of the home have not been forwarded immediately as required to the Director and that he would be reviewing the home's complaints process. [s. 22. (1)]

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 to immediately forward any written complaints that have been received concerning care of a resident or the operations of the home to the Director, to be implemented voluntarily.

WN #3: 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 staff participate in the implementation of the infection prevention and control program related to management of soiled linen and briefs at resident bedsides.

This inspection was as a result of complaints and critical incidents reported by the home regarding written complaints made by resident #001's Substitute Decision Maker (SDM). Resident #001's SDM had concerns related to infection control practices of nursing staff in the home with residents as identified by the following:

a)This complaint identified infection prevention and control concerns regarding how Personal Support Workers(PSW's) manage soiled continence products in resident care areas. This complaint indicated that soiled continence products were being placed on resident's beds on top of clean linen and not disposed of in garbage bags immediately as required.

Inspector #547 interviewed resident #001's SDM regarding this complaint, and the SDM indicated that they would place soiled linen and continence products on top of clean blankets while they finished resident care, and then remove the soiled items when they

leave, leaving the clean blanket, that was now soiled on the resident. The SDM indicated this was not sanitary for the resident.

b)This critical incident identified a complaint made by resident #001's SDM on a specified date regarding incidents observed over three specified dates earlier of infection prevention and control issues related to how PSW's manage soiled continence products in resident care areas.

This complaint indicated on one specified date, the PSW was observed by the SDM to place a soiled continence product on the resident's table top where food is placed for the resident at meals and snack service. The soiled continence product was then thrown in the garbage after care was provided to the resident. This same incident occurred again on two separate specified dates.

Inspector #547 interviewed resident #001's SDM regarding these incidents, and on each occasion, the table top was not washed for the resident after the soiled continence product was disposed of in the garbage.

c)This complaint indicated on a specified date, that the SDM observed a PSW place a soiled continence product on the floor next to the garbage where the soiled continence product is suppose to be disposed of. The SDM indicated that the PSW staff know they are suppose to use the garbage bags, yet the just don't do what they are suppose to do. The SDM indicated the PSW staff will tell you the right way to do things, but they do not do this when they are providing care. The SDM indicated that the PSW staff do this in front of SDM, when present in the resident's room.

Interviews with PSW #108 and #119 on September 25, 2017 working in the home, indicated to Inspector #547 that they are to dispose of soiled continence products in the small black garbage bags located next to resident beds, and when they are done with resident care, they close and remove these small black bags and place them in the two soiled continence product garbage bins located in the hallways. Upon observation of these garbage bin contents in a specified hallway, it was noted that the continence products were not placed inside small black garbage bags as required. PSW #119 indicated that sometimes they do not have any supply of black garbage bags. PSW #108 and #119 further indicated that the home's process is that they are not allowed to place soiled continence products on the floor, so they will roll the soiled briefs in clean linen until they are finished with the resident's personal care to dispose of the soiled brief in the garbage bins in the hallway. PSW #108 further indicated they are not allowed to place

soiled briefs on resident chairs, tables or desks however has seen this practice done in the home.

Inspector #547 then observed 5 rooms in a specified hallway including resident #001's room to have small garbage bag inside a small garbage bin next to resident beds, that further contained several small replacement garbage bags.

On October 25, 2017 Housekeeper #111 indicated to Inspector #547 that she does find soiled continence products and soiled linens in resident bedrooms and bathrooms. Housekeeper #112 indicated to Inspector #547 that she also has found soiled linens on residents beds, floors and window sills. Housekeeper #112 further indicated that she also works in the home's laundry room, and that soiled linen management is an ongoing issue in the home. Laundry room staff will find soiled briefs inside the soiled linens bags sent to laundry when nursing staff are suppose to place the soiled briefs into black garbage bags and then into garbage bins that are specifically in resident care hallways to dispose of soiled briefs. Laundry room staff also find fecal matter, that is suppose to be rinsed off in the home's hoppers in the nursing units before they are placed in the soiled linen bags.

On September 26, 2017 Inspector #547 interviewed PSW #117 working on a specified wing of the home regarding management of soiled continence products during resident care. PSW #117 indicated that the soiled continence products are to be placed inside the small garbage next to the resident beds that have a small black garbage bags. PSW #117 indicated that once the resident care is completed, they tie the small black bag and remove it from the room and dispose of them inside the large garbage bags in the hallway for soiled continence products. PSW #117 indicated the home always has enough supply of these small garbage bags or they ask the housekeeping staff to replenish. Inspector #547 observed the large garbage bins in the resident care hallways that PSW #117 indicated was for disposal of soiled continence products, and observed that none of the soiled briefs were placed inside small black garbage bags. PSW #117 indicated that she was not sure why these soiled briefs were not disposed of with small black garbage bags as required.

On a specified date, resident #001's SDM indicated to Inspector #547 that PSW #117 just provided care to resident #001, and placed a soiled continence product on the material seat cushion of the visitors chair inside resident #001's room. This material chair was located right next to this small garbage bin where the soiled continence products are to be disposed of and said that "PSW staff don't realize how this can affect these residents that live in these rooms".

The Extendicare Assist Nursing Consultant indicated to Inspector #547 that soiled continence products are to be placed only in the small black garbage bags next to the residents beds and that placing these items on resident's clean bed linen, tables, desks, or chairs is not acceptable.

As such, nursing staff have failed to participate in the implementation of the infection prevention and control program related to management of soiled linen and continence products at resident bedsides. [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 to ensure that nursing staff implement infection prevention and control practices related to management of soiled linen and briefs at resident bedsides, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 29. Every licensee of a long-term care home shall ensure that when a resident is reassessed and the resident's plan of care is reviewed and revised under subsection 6 (10) of the Act, any consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act, that is relevant, including a regulated document under paragraph 2 of subsection 227 (1) of this Regulation, is reviewed and, if required, revised. O. Reg. 79/10, s. 29.

Findings/Faits saillants :

1. The Licensee has failed to ensure that when a resident is reassessed and the resident's plan of care is reviewed and revised under subsection 6(10) of the Act, any consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996 is revised.

A Critical Incident Report was submitted by the home on a specified date, regarding a

written complaint that was given to the home about resident #001's plan of care changes. This written complaint indicated that the resident's plan of care regarding turning and positioning schedule plan was changed. The resident had a turning and positioning schedule developed by nursing staff and the resident's SDM to direct care staff with the different positions required for the resident at specified times. The SDM developed a voiding diary that the PSW's were to document when the resident's brief was changed.

On a specified date, resident #001's SDM indicated to Inspector #547 that the DOC informed him/her that they were going to change the resident's plan of care related to the documentation on the voiding schedule as well as the turning schedule developed for the resident. The SDM informed the DOC that day, that he/she did not want to change anything related to the resident's care. The SDM indicated to the DOC that the current schedule and plan was effective for the resident in order to be repositioned and the resident's brief changed as required in the plan of care. The SDM further indicated to the DOC that the resident did not have any skin pressure areas and appeared to be comfortable with the existing plan. The SDM indicated to have returned to the home the next day, and the DOC had implemented changes to the resident's plan of care. The SDM was upset and specifically told the DOC and RN #100 that he/she did not want to change anything in the resident's plan of care.

On October 3, 2017 RN #100 indicated to Inspector #547 that she recalled this incident, as she did not want to change anything with resident #001's plan of care, as it should only be done when the SDM is in agreement and the SDM was very upset with the suggested changes. RN #100 further indicated that for all plans of care, the resident or their SDM have to agree with the plan and interventions as it affects the residents care.

On October 3, 2017 the Extendicare Assist Nursing Consultant indicated to Inspector #547 that the resident had a turning schedule based on the resident's schedule that the registered nursing staff implemented with the resident's SDM. The Extendicare Assist Nursing Consultant indicated the SDM implemented a documentation of brief changes as part of this turning schedule in place, to assist the family in knowing the resident was turned and brief was changed when they were not in the home as reassurance. The Extendicare Assist Nursing Consultant indicated that if that developed plan of care was changed, the SDM should have been involved in the decision. If the SDM was not in agreement with the change, the home should not have implemented this new process, until further discussion and explanation with SDM, to better understanding in order to agree to the new process. [s. 29.]

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Issued on this 29th day of November, 2017

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

Original report signed by the inspector.