Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 15, 2022	2022_905683_0001	001311-22	Proactive Compliance Inspection

Licensee/Titulaire de permis

CVH (No. 1) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

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

West Park Health Centre
103 Pelham Road St Catherines ON L2S 1S9

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

LISA BOS (683), LISA VINK (168)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Proactive Compliance Inspection.

This inspection was conducted on the following date(s): January 24-28, 31 and February 1, 2022

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Environmental/Food Service Manager, Social Worker/Infection Prevention and Control (IPAC) lead, Resident Assessment Instrument (RAI) Coordinator/Restorative Lead, Nursing Clerk, Recreation Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), dietary staff, maintenance staff, housekeeping staff, recreation staff, screening staff, residents and families.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, infection prevention and control (IPAC) practices, meal service, medication administration, and reviewed clinical records, relevant policies and procedures, meeting minutes, training records and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

8 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	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment resident meal time assistance, so that their assessments were integrated, consistent with and complemented each other.

A) A resident's plan of care identified that they required assistance with meal set up and supervision of one staff to cue and to encourage them to eat.

The Minimum Data Set (MDS) assessment identified that the resident required supervision with one person to assist with eating. The Quarterly Nutrition Assessment completed by the Registered Dietitian (RD) identified that the resident required two person physical assistance during mealtimes.

There was no documentation to support that the resident had a change in care needs

related to eating between the MDS assessment and Quarterly Nutrition Assessment.

The resident was observed at the noon meal to require set up assistance of staff.

The DOC acknowledged that the assessment completed by the RD was not correct, as no residents in the home required two person assistance with eating.

Sources: Observations of the resident at the noon meal and review of their care plan, progress notes and assessments and interviews with the DOC and other staff.

B) A resident's plan of care identified that they required supervision at meals.

The MDS assessment identified that the resident required supervision with set up assistance with eating. The Quarterly Nutrition Assessment completed by the RD identified that the resident required extensive assistance at mealtimes with two person feeding assistance, and set up help at mealtimes.

There was no documentation to support that the resident had a change in care needs related to eating between the MDS and Quarterly Nutrition Assessments.

The resident was observed at the noon meal to require set up assistance of staff.

The DOC acknowledged that the assessment completed by the RD was not correct, as no residents in the home required two person assistance with eating.

Sources: Observations of a resident at the noon meal and review of their care plan, progress notes and assessments and interviews with the DOC and other staff. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan related to set up assistance at meals.

A resident was observed eating in their room during the noon meal service. They ate their main course, but the lid was still on their soup. They reported that they could not open it.

The resident's care plan indicated that they required supervision with set up assistance at meals. A RPN assisted the resident to open their soup, upon request of the inspector

and acknowledged that the staff should have assisted them to open it.

The DOC acknowledged that according to the resident's plan of care, they required set up assistance with eating and that staff should have removed the lid of their soup for them.

Failure to provide set up assistance with meals put a resident at risk of insufficient food/fluid intake.

Sources: A resident's clinical record; resident observation; resident interview; interview with a RPN and the DOC [s. 6. (7)]

3. The licensee has failed to ensure that a resident's plan of care was revised when the care set out in the plan was no longer necessary related to the use of a medication.

A resident's written plan of care indicated that they were on a specific medication. According to their electronic Medication Administration Record (eMAR), they were not on the specified medication.

A RPN confirmed the resident was not on the medication. The DOC reported that the resident was admitted with an order for the medication and that the order was discontinued at that time. They acknowledged that the resident's plan of care was not updated to indicate that they no longer required the medication.

Sources: A resident's clinical record; interview with a RPN and the DOC [s. 6. (10) (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 staff and others involved in the different aspects of care of the resident collaborate wth each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that an area where drugs were stored was kept locked at all times, when not in use.

The room labelled "med room" on the second floor which included an unlocked treatment cart and fridge which contained boxes of insulin cartridges was observed unlocked and unattended by staff.

A RPN confirmed that the room which contained drugs, was unlocked and unattended at the time of the observation.

Failure to ensure that the area where drugs were stored was locked at all times had the potential for residents, visitors or staff to access the drugs.

Sources: Observations of the medication room on the second floor and an interview with a RPN. [s. 130. 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 that all areas where drugs are stored are kept locked at all times, when not in use, 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 all staff participated in the implementation of the infection prevention and control (IPAC) program, related to the use of personal protective equipment (PPE).

Public Health declared a COVID-19 outbreak at the long-term care home. The home's IPAC lead reported that the entire home was in outbreak and all residents were put on droplet/contact precautions. Signage was posted throughout the first and second floors indicating that N95 respirators were required, and residents were served meals in their rooms.

A) The long-term care home's "COVID-19 Universal PPE Guidelines" policy was reviewed. It indicated that for all residents who were on droplet/contact precautions (isolation), all staff and essential visitors were to don eye protection (face shields preferred), gowns, gloves, and a procedure mask or N95 respirator, as determined in the province-specific Point of Care Risk Assessment (PCRA).
When residents were cohorted in Ontario, the policy indicated that all staff and essential visitors were to:
-Don a N95 respirator when entering the affected home area;
-N95 could remain on between resident rooms if the respirator was fully covered by a face shield and had not been contaminated while in the isolation room;

-Prior to exiting the isolation room, the face shield was to be cleaned and disinfected or discarded if disposable; and
-If goggles were used, the N95 respirator was to be doffed before exiting the isolation room.

(i) A PSW was observed to enter a resident's room to assist with setup of the noon meal. The PSW donned full PPE, including goggles and a N95 respirator; however, upon exiting the room, they doffed their gloves and gown, but did not clean their goggles or change their N95 respirator as required. They stated that they did not need to clean their goggles upon exiting the resident's room.

(ii) Two PSWs were observed exiting a resident's room after providing care. Both staff members doffed their gloves and gown upon exiting the room; however, did not clean their goggles or change their N95 respirator as required. One PSW indicated they did not need to clean their goggles and the other PSW acknowledged that they should have cleaned their goggles.

(iii) A PSW was observed to enter four different resident rooms to deliver the noon meal. The PSW wore eye protection and a N95 respirator; however, did not don or doff gloves or a gown before or after they entered or exited the rooms, nor did they clean their eye protection and change their N95 respirator as required. They reported that they did not need gloves, a gown or to clean their eye protection and change their N95 mask when dropping off meal trays.

(iv) A PSW was observed to enter two different resident rooms to obtain resident meal choices for the noon meal. The PSW wore eye protection and a N95 respirator; however, did not don or doff gloves or a gown before or after they entered or exited the rooms nor did they clean their eye protection as required.

The IPAC lead indicated that IPAC audits had identified gaps and opportunities for training staff.

The ED and IPAC lead acknowledged that according to the home's policy, staff were required to don full PPE including eye protection, gowns, gloves and a N95 respirator when they entered resident rooms. They also acknowledged that if staff wore goggles, they were required to clean them when they exited resident rooms and change their N95 respirator.

Failure to wear appropriate PPE and to clean/disinfect eye protection as required put residents, staff, and visitors at risk due to the possible spread of infection.

Sources: The home's "COVID-19 Universal PPE Guidelines" policy, last updated December 22, 2021; observations throughout the home; interviews with the IPAC lead and ED.

B) The long-term care home's "COVID-19 Universal PPE Guidelines" policy was reviewed. It indicated that for all residents who were on droplet/contact precautions (isolation), and who were cohorted in Ontario, all staff and essential visitors were required to don a N95 respirator when they entered the affected home area.

(i) Two external service providers were observed on the second floor of the home and they each wore a surgical mask.

(ii) A technician was observed leaving a resident home area and they wore a surgical mask. The DOC reported they were in the home to assess two residents.

(iii) A staff member was observed portering a resident from the front of the home, down the hallway of the resident home area. They wore a surgical mask.

(iv) Two staff members were observed walking on the first floor resident home area, wearing surgical masks.

(v) A resident was observed with an essential visitor in their room. The visitor wore a surgical mask along with a face shield and gown.

(vi) A resident was observed with an essential visitor, while on the resident home area. The visitor wore a surgical mask along with a face shield and gown.

The DOC reported that the home did not provide N95 fit testing for essential visitors.

In discussions with the ED and IPAC lead, they acknowledged that according to the home's policy, all staff and essential visitors should have donned a N95 respirator when they entered the outbreak home areas, which included both floors of the home. They confirmed the individuals observed by the inspectors were staff members of the home or essential visitors.

Failure to wear appropriate PPE put the staff members, essential visitors, residents and others at risk due to the possible spread of infection.

Sources: The home's "COVID-19 Universal PPE Guidelines" policy, last updated December 22, 2021; mealtime observations; interviews with the IPAC lead, DOC and ED. [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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents when active screening for COVID-19 did not occur as per Directive #3.

In accordance with Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, homes were required to ensure that all individuals were actively screened for symptoms and exposure history for COVID-19 before they were allowed to enter the home, with the exception of first responders in emergency situations.

Two external service providers were observed on a home area.

The DOC indicated that the external service providers entered/exited the home through a side door, and they were unable to locate a screening record for them.

The ED and IPAC lead acknowledged the home did not have a process in place for screening the identified individuals.

Failure to complete active screening increased the risk that COVID-19 symptoms may not have been identified.

Sources: Directive #3; home area observations; interviews with the IPAC lead, DOC and ED. [s. 5.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system for the lounge area on the second floor clearly indicated when activated where the signal came from.

The second floor lounge communication and response system was activated by the inspector.
When activated, the lounge area ceiling dome light illuminated.
The communication and response display receiver, at the second floor nurses station, did not display that the call was activated.
Two PSWs identified that the second floor display receiver did not include a signal for the lounge area. It was reported that the signal would display at the first floor nurses station and it was the responsibility of first floor staff to alert second floor staff that the call was activated.
Observation of the first floor communication and response system display receiver confirmed that when the second floor lounge call was activated the code 307 B appeared.
A RPN reported that the code 307 B was for the second floor lounge area.

Failure to ensure that the communication and response system clearly indicated when

activated where the signal came from had the potential for staff to be unaware of situations where assistance was needed.

Sources: Observations of the communication and response system on the first and second floors and interviews with nursing staff. [s. 17. (1) (f)]

2. The licensee has failed to ensure that the resident-staff communication and response system for the second floor lounge area, which used sound to alert staff, was calibrated so that the level of sound was audible to staff.

The second floor lounge communication and response system was activated by the inspector.
When activated, the lounge area ceiling dome light illuminated; however, there was no sound audible on the second floor.
Two PSWs confirmed that no sound was audible on the second floor when the system was activated in the second floor lounge. It was reported that the sound was audible on the first floor and it was the responsibility of first floor staff to alert second floor staff that the system was activated.
Observation on the first floor confirmed that the communication and response system for the second floor lounge was audible on the first floor.

Failure to ensure that the communication and response system in the second floor lounge was calibrated so that the level of sound was audible to staff on the second floor had the potential for staff to be unaware of situations where assistance was needed.

Sources: Observations of the communication and response system on the first and second floors and interviews with nursing staff. [s. 17. (1) (g)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was bathed, at a minimum, twice a week by the method of their choice, unless contraindicated by a medical condition.

Point of Care (POC) records for a resident identified that they preferred a shower twice a week.
The POC records noted that bathing was recorded as "not applicable" on three occasions, as recorded by a PSW.
The PSW reported that the resident was not showered on the identified dates as there was initially direction not to bathe residents during the COVID-19 outbreak.
The home declared a COVID-19 outbreak that month.

Sources: A review of care plan and POC records; observations of a resident; interview with a PSW. [s. 33. (1)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Residents' Council and the Family Council was sought out in developing and carrying out the satisfaction survey.

A review of the Residents' Council meeting minutes did not identify any indication that their advice was sought out in the development of the satisfaction survey. The President of Residents' Council and an active member of the council could not recall if their advice was sought out in developing and carrying out the survey.

The President of Family Council stated that they did not recall being asked for their advice on developing and carrying out the satisfaction survey prior to it being sent out in October 2021. There were no meeting minutes available to review.

The Recreation Manager and ED acknowledged that the advice of the Residents' and Family Councils was not sought out in developing and carrying out the most recent satisfaction survey.

Sources: Residents' Council meeting minutes; interviews with Residents' Council members, the President of Family Council, the Recreation Manager and the ED. [s. 85. (3)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

COVID-19 is a designated disease of public health significance (Ontario Regulation 135/18) and confirmed and suspected cases of COVID-19 are reportable to the local public health unit under the Health Protection and Promotion Act, 1990 (HPPA).

A COVID-19 outbreak was declared at the home and a Critical Incident System report was not submitted until three days later, to inform the Director of the outbreak.

The ED acknowledged the outbreak was reported to the Director three days after it was declared by Public Health.

Sources: Critical Incident System Report; interview with the ED. [s. 107. (1) 5.]

Issued on this 17th day of February, 2022

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

Original report signed by the inspector.