Ontario

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

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: October 16, 2023

Inspection Number: 2023-1184-0005

Inspection Type:
Proactive Compliance Inspection

Licensee: Carveth Nursing Home Limited

Long Term Care Home and City: Carveth Care Centre, Gananoque

Lead Inspector	**Inspector Digital Signature**
Polly Gray-Pattemore (740790)	Pauline L Gray Pattemore Digitally signed by Pauline L Gray Pattemore Date: 2023.10.31 10:03:42 -04'00'

Additional Inspector(s)
Heath Heffernan (622)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 18-28, 2023

The following intake was inspected in this Pro-Active Compliance Inspection (PCI):

- Intake: #00096684 was related to a PCI.

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

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

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 138 (1) (a) (i)

The licensee failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.

Rationale and Summary:
On September 26, 2023, Inspector #740790 observed in the morning seven ensure bottles in a medication fridge, that was located in the medication room near the nursing one station. During an interview with management, they acknowledged that the medication fridge is used exclusively for drugs and drug-related supplies and confirmed that the ensure bottles should not be stored in the medication fridge.

On September 26, 2023, Inspector #740790 observed in the afternoon that the ensure bottles were removed from the medication fridge.

Sources: observations of September 26, 2023; and interview with management.
[740790]

Date Remedy Implemented: September 26, 2023

WRITTEN NOTIFICATION: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of the care set out in two residents' plan of care has been documented.

Rationale and Summary
Review of the Point of Care (POC) task documentation for the completion of resident activities of daily living indicated, that there was missing documentation related to a resident's bathing and hygiene on two dates, oral care on four dates and another resident's oral care on three dates.

During separate interviews with Inspector #622 on September 27, 2023, two staff members stated that was provided to the residents, however documentation was not being completed.

Sources: review of Point of Care tasks documentation; and interviews with staff.
[622]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that staff to resident abuse had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary
On September 21, 2023, Inspector #622 interviewed a resident and their Substitute Decision Maker, who made allegations of three separate incidents related to alleged staff to resident verbal and or physical abuse as follows:

1) A staff member continued to provide care when the resident complained of pain while being repositioned. The SDM reported the allegation to management.

2) A resident contacted their SDM and the SDM placed a telephone call to the long-term care home to request staff assistance for the resident. The resident alleged that an unknown staff member entered their room and reprimanded them for having their SDM call the long-term care home. The SDM

reported the allegation to management.

3) A staff member transferred a resident using a mechanical lift. The resident alleged that the staff member continued to perform the lift, after they complained of pain, and then accused the resident of hurting their back and made inappropriate comments.

This alleged incident of staff to resident abuse had not been reported to the home's staff or management by the resident or their SDM. Inspector #622 reported the allegation of abuse to management on September 21, 2023, at 1500 hours.

Review of the Ministry of Long-Term Care reporting portal on September 26, 2023, indicated that there were no Critical Incident (CI) reports submitted for the three incidents of alleged staff to resident abuse.

During separate interviews on September 28, 2023, two management staff members stated that they had not reported the incidents of alleged abuse to the Ministry of Long-Term Care.

By not reporting allegations of staff to resident abuse, places the residents at risk for ongoing situations of alleged abuse.

Sources: review of the Ministry of Long-Term Care reporting portal; interview with a resident; and interviews with management.
[622]

WRITTEN NOTIFICATION: Doors in a home

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

Rationale and Summary
On September 18, 2023, Inspector #622 observed housekeeping room #239 had a code punch lock on the door, however, could be opened without using the code. The room contained four unlocked electrical panels and a natural gas heating unit. A resident was sitting on their walker in front of the door. There was also an unnumbered storage room door on the west wing that was ajar, inside were storage shelves and slings for mechanical lifts.

On September 21, 2023, Inspector #622 observed an unnumbered room with a code punch lock on the door at the entrance to the west wing across from the nurse's station. The auto-closure mechanism on the door had not closed the door fully. The room contained hand sanitizer, mechanical lift batteries in chargers, bed alarms and suction machines. No residents were in the area at the time; however, the room was at the main intersection in the hallway where many residents pass by and sit.

On September 28, 2023, Inspector #622 observed the door to the unnumbered room situated at the entrance to the west wing across from the nurse's station that contained bed alarms, hand sanitizer, mechanical lift batteries in chargers and suction machines, could be opened without using the code on the key punch lock. Residents were sitting in the area at the time of the observation.

During an interview with Inspector #622 on September 28, 2023, management indicated that the non-residential doors that allowed Inspector #622 access during the inspection, should have been kept closed and always locked.

By having non-residential rooms containing equipment and supplies that were not kept closed and locked, places residents at risk for injury.

Sources: observation of non-residential doors; interview with management and other staff.
[622]

WRITTEN NOTIFICATION: Care conference

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 30 (1) (a)

The licensee has failed to ensure that an interdisciplinary team care conference was held within six weeks following a resident’s admission to discuss the plan of care and any other matters of importance to the resident and their substitute decision-maker.

Rationale and Summary
A resident’s electronic progress notes did not contain documentation that would indicate that the six-week post admission interdisciplinary team conference had taken place. The hard copy interdisciplinary team conference form stated that they were unable to contact the resident’s Substitute Decision Maker (SDM). There was no other documentation to indicate that the six-week post admission interdisciplinary team conference had been completed on a different date.

During separate interviews with Inspector #622, the resident and their SDM stated that they had not been involved in the interdisciplinary team conference.

Sources: review of the electronic progress notes; hard copy interdisciplinary team conference form; and interviews with a resident and their SDM.
[622]

WRITTEN NOTIFICATION: Housekeeping.

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)

The licensee has failed to ensure disinfection of tubs in accordance with manufacturer's specifications.

Rationale and Summary:
During an interview with a staff member, they acknowledged that they disinfect the tub after each resident bath with contact time of anywhere from two minutes to ten minutes, ten minutes for a resident on contact precautions and two to three minutes for a resident not on additional precautions. During an interview with management, they confirmed that the ARJO All-Purpose Disinfectant used for disinfection of tubs has a contact time of ten minutes and during an interview with another management staff member, they acknowledged disinfecting contact time of tubs ten minutes as per manufacturer's instructions.

Review of the licensee's Personal Care-Tub/Shower Bath policy indicates when a resident has a bath, after each bath, clean the tub with Arjo Disinfectant. Review of the tub manufacturer's ARJO Quick Reference Guide - Cleaning and Disinfection, indicates allow appropriate contact time according to the instructions of the disinfectant and review of the ARJO All-Purpose Disinfectant directions indicate treated surfaces are to remain wet for ten minutes after each resident bath.

By not ensuring that disinfection of tubs in accordance with manufacturer's specifications, the residents were at increased risk of infection.

Sources: interview with a staff member; interviews with management; Personal Care-Tub/Shower Bath policy (reviewed/revised date June 13, 2023); ARJO Quick Reference Guide - Cleaning and Disinfection (08.AR.09_3EN); and ARJO All-Purpose Disinfectant directions.
[740790]

WRITTEN NOTIFICATION: Infection prevention and control program.

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure they implemented any standard or protocol issued by the Director with respect to infection prevention and control, specifically the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022, 9.1 indicates at a minimum, additional precautions shall include point-of-care signage indicating that enhanced IPAC control measures are in place and additional PPE requirements including appropriate selection application, removal and disposal.

Rationale and Summary:
A review of the list of residents in isolation indicate four residents on contact precautions. On September 18, 2023, Inspector #740790 observed that there was no point-of-care signage indicating that enhanced IPAC control measures in place and additional PPE requirements at entry to any of the four resident rooms. On September 19, 2023, Inspector #740790 observed an additional precaution sign indicating required contact precautions posted at entry to the four resident rooms.

Review of the licensee's Contact, Droplet, Airborne, and/or "Other" Precautions policy indicates that a contact precaution sign be posted on the door along with a visitor awareness sign to report to nursing staff in charge of the nursing area and precaution sign visible on entry to room. During an interview with the IPAC Lead, they confirmed there should be signage at the resident door that would say contact precautions and the required personal protective equipment (PPE).

By not ensuring that an additional precaution sign indicating required precautions posted at entry to room, the residents were at increased risk of infection.

Sources: observations of September 18 and 19, 2023; interview with the IPAC Lead; Contact, Droplet, Airborne, and/or "Other" Precautions - Isolation and Precautions Defined, PPE required, Staff Approached to Care Identified policy (last revised date of August 28, 2023); and Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022.
[740790]

WRITTEN NOTIFICATION: Security of drug supply

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 139 1.

The licensee failed to ensure that steps were taken to ensure the security of the drug supply, including all areas where drugs are stored shall be kept locked at all times, when not in use.

Rationale and Summary:
On September 26, 2023, Inspector #740790 observed in the resident unit hallways that four personal support worker (PSW) treatment carts were unlocked and the top drawer of each cart had multiple resident prescribed medications such as ointments and lotions. On the same day, Inspector #740790 observed in the resident unit hallways that three PSW treatment carts had the key inserted in the key cylinder (lock body) and with multiple resident medications such as ointments and lotions in the top drawer. On September 27, 2023, Inspector #740790 observed in the resident unit hallways that six PSW treatment carts were locked and the key to lock each cart secured to the back of the cart by tape.

During an interview a staff member, they acknowledged that the PSW treatment carts have resident medications allocated to PSWs to give, the key to access a treatment cart hangs on the back of the cart secured by tape, and that anyone who knows how to work a key can access the PSW treatment carts. During an interview with management, they confirmed that the PSW treatment cart is to be locked when not in use. Review of the licensee's Medication Storage Safe policy indicates all medication carts to be locked and Medication Protocol policy indicates medications are stored in locked cabinets or medication carts at all times.

By not ensuring that all medication carts locked and secured, including PSW treatment carts with resident medications, the residents were at increased risk of their drugs not being secured and accessed by anyone who knows how to use a manual lock.

Sources: interview with a staff member and management; 080 Meds Mgmt - Medication Storage Safe policy (reviewed/revised June 13, 2023); 054 Meds Mgmt - Medication Protocols policy (reviewed/revised June 13, 2023); and observations of September 26 and 27, 2023.
[740790]

WRITTEN NOTIFICATION: Continuous quality improvement committee.

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.

The licensee has failed to ensure that the continuous quality improvement committee shall be

composed of at least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

Rationale and Summary:
During an interview with the Quality Improvement (QI) Lead, they acknowledged that they had not invited an employee of the licensee who has been hired as a personal support worker (PSW) or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52 to be a member of the QI committee. Review of the 2023 QI monthly minutes indicate that for the months of March, May, June, July and August, a PSW was neither an attendee nor a member absent with regrets.

Sources: interview with QI Lead; and 2023 QI monthly minutes.
[740790]