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
Jan 8, 2020	2019_643111_0024	018121-19, 018600-19, 018914-19, 019896-19, 020009-19	Complaint

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Hope Street Terrace
20 Hope Street South PORT HOPE ON L1A 2M8

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 3-6, 9 and 10, 2019

There were five complaints received as follows:
-Log #020009-10 and #019896-19 related to medication management, pain management, bathing, housekeeping and management of complaints.
-Log #018914-19 related to continence care.
-Log #018600-19 related to insufficient staffing, bathing and maintenance.
-Log #018121-19 related to housekeeping and bathing.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the acting Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Environmental Services Manager (ESM), Maintenance Worker, Housekeeping (HSK), Pharmacist, Nursing Clerk (NC), Nursing Administrative Scheduling Clerk (NASC) and residents.

During the course of the inspection, the inspector: observed residents, reviewed resident health records, investigations, employee records, staffing schedules, bath lists, bathing audits, complaints, maintenance records and reviewed the following policies: Odours, Maintenance, Collecting and Sorting Soiled Laundry and Housekeeping Duties.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Pain
Personal Support Services
Reporting and Complaints
Sufficient Staffing

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

4 WN(s)
4 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. 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 :

The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

There were two anonymous complaints received indicating the tub on the second floor had been out of service for a number of months, resulting in baths not being provided. The complaint indicated the shower on a specified unit was also not working.

Observation by the Inspector on a specified date, indicated there was a larger tub and shower room available beside the nursing station on each floor. There was also a second smaller tub and shower room on each floor. All of the tubs and showers were in working order. During the observation of these areas, the Inspector noted that in the common areas (hallways, tub/shower rooms, resident rooms and around nursing stations) throughout the second and third floor, there were several areas in disrepair. In addition, observation of the bathroom of a specified resident room had a large area of damaged flooring and walls.

Review of the maintenance log books indicated the tub on a specified floor was noted to be not working and no indication when the tub was repaired. There was also a note indicating a shower area on a specified floor was also in need of repair on a specified date but no indication when the area was repaired.

During separate interviews two PSWs (#108 and #109), they both indicated awareness that the tub on a specified floor was previously not in use and was not replaced for a

number of months.

During an interview with resident #010, they indicated awareness that the tub was broken for a number of months and baths were not provided as a result.

During an interview with the Environmental Services Manager (ESM), they indicated they were made aware that the tub on a specified floor beside the nursing station was not working on a specified date. The ESM indicated because of poor service response, the part being on back order and the tub being very old, the a new tub had to be purchased. The ESM confirmed the new tub was not installed for a number of months, making it not available for use. The ESM indicated awareness that a shower on a specified floor was also out of service due the flooring disrepair and required the entire flooring to be repaired before the shower was back in use. The ESM indicated the shower was out of service for a number of weeks. The ESM then toured the home with the Inspector and confirmed that there was multiple areas with large damaged walls and trim throughout the home (hallways, tub/shower rooms, residents rooms, around nursing stations) that were in need of repair. The ESM was also toured a specified resident room and confirmed there was areas on the floors and walls outside of the bathroom that were also in need of repair. The ESM provided the Inspector with an annual paint touch up schedule but there was no documented evidence to indicate that any paint touch-ups actually occurred.

During an interview with the ED, they confirmed awareness that when they started in the home, they noted large areas of disrepair throughout the home and provided the ESM with an Environmental Action Plan (dated with a specified date) that included repairing of wall damage, baseboards and wall painting. The ED confirmed that there was no indication that any of the actions occurred. The ED indicated awareness that the tub on a specified floor was also out of use and informed the ESM to order a new tub, as the tub could not be out of service for that length of time.

The licensee has failed to ensure that the home (hallways, tub/shower rooms, nursing stations and resident rooms) and the equipment (tubs/showers) were maintained in a safe condition and in a good state of repair.

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 and equipment is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the staffing plan provided a staffing mix that was consistent with the resident's assessed care and safety needs.

There were four anonymous complaints received, all related to care not being provided due to PSW staffing shortages.

During an interview with resident #008, they indicated their preference was to have a tub

bath twice a week on specified days and times. The resident indicated that they missed their bath recent bath and was told by staff that they did not have time and would reschedule their bath the following day but the bath was never provided. The resident indicated PSW #114 was supposed to provide their bath. The resident indicated they frequently miss one of their scheduled bath days due to lack of staffing and was an ongoing issue with missed baths.

Review of the point of care (POC) for resident #008 under bathing during a specified period, indicated the resident missed a number of their scheduled baths. . There was no documented evidence in the residents progress notes to indicate why the bath was not provided.

During an interview with resident #010, they indicated that they prefer two baths per week, on specified days and shifts. The resident indicated they were frequently not getting their baths when the bath tub was broken and was not happy about it.

Review of the point of care (POC) for resident #010 related to bathing provided during a specified period, indicated the resident did not receive a number of their scheduled baths during that period. There was no documented evidence in the residents progress notes to indicate why the bath was not provided.

During an interview with resident #011, they indicated they preferred a tub bath twice a week on specified days and shifts. The resident indicated they frequently do not receive their bath and indicated they did not receive their most recent bath and the bath was not rescheduled. The resident indicated the tub was broken for quite a while and the staff were supposed to take them to another unit but that never occurred. The resident was not happy about the lack of bathing that was provided.

Review of the point of care (POC) for resident #011 related to bathing provided during a specified period, indicated the resident did not receive a number of their scheduled baths during that period.There was no documented evidence in the residents progress notes to indicate why the bath was not provided.

During an interview with PSW #114, they indicated that resident #008 was to receive two baths per week on specified days and shifts. The PSW confirmed the resident was not provided their most recent scheduled bath and had not yet been rescheduled. The PSW confirmed they did not inform the charge nurse that the bath for resident #008 was not provided.

Review of the master staff schedule for PSWs indicated the home has a total of 97 residents, with 48 residents on the second floor and 49 residents on the third floor. There were two PSWs assigned to work on each floor during the night shift, five PSWs assigned to work on each floor on the day shift and four PSWs assigned to work on each floor on the evening shift. The PSW master schedule was changed in September 2019, to accommodate both full-time and corresponding part-time lines as previously this was not in place. As of December 1, 2019, the home had a number of part-time and full-time PSW positions vacant.

Review of the worked schedules for PSWs during a specified period, indicated there were a number of dates and shifts when the home was working short staffed of PSWs on each floor, which mainly occurred on specified shifts.

During an interview with the Nursing Clerk (NC), they confirmed the home has been working short staffed with PSWs. The NC indicated the home has a Plan B contingency plan in place, in the event they were working short staffed with one PSW on each floor, there was a redistribution of the resident workload assignments. The NC indicated they also had different agencies that they use for replacement of PSWs. The NC confirmed the home had a number of full-time and part-time PSW vacancies, which was contributing to shortage of PSW staff.

During an interview with the Nursing Administrative Scheduling Clerk (NASC), they confirmed the home had ongoing concerns with short staffing of PSWs and mainly occurred on specified shifts. The NASC confirmed that the home utilized a number of agency staff as there were multiple vacancies in PSW lines. The NASC also indicated the master schedule was changed on a specified date, due to concerns with replacing PSW shifts, from a job sharing line rotation to a full-time and part-time line rotation. The NASC confirmed the shortage of PSW staff had not improved.

During an interview with the acting DOC, they indicated there were a number of vacancies for PSWs that had not been filled. The acting DOC indicated they had attempted to hire PSW staff, but then the staff quit. The acting DOC indicated they also used a number of agencies and agency PSW staff to replace the PSW shortages. The acting DOC indicated they were constantly recruiting and trying to replace PSW vacancies. The acting DOC confirmed awareness of several dates when the home was working short staffed of PSWs and resulted in bathing not being provided as a result. The acting DOC indicated awareness of complaints the home had received related to baths

not being provided and initiated a bathing audit because they were concerned that the baths were not being provided to residents. The acting DOC was not aware of how many PSW vacancies were currently in place. The acting DOC indicated the PSW staff shortages frequently occurred on specified dates.

During an interview with the Executive Director (ED), they indicated awareness of a number of shifts with short staffing of PSWs and the home's use of a number of shifts and dates, when agency PSWs were in use in the home. The ED confirmed that there were several dates when the home was also working short staffed of PSWs that included the BSO PSW, laundry PSW and the restorative care PSWs. The ED indicated they have now filled all of the full-time PSW vacancies and half of the remaining part-time PSW vacancies.

The licensee had failed to ensure that the staffing plan provided a staffing mix that was consistent with the resident's assessed needs related to bathing, as there was a number of dates and shifts where the home was working short staffed with PSWs during a specified period.

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 staffing plan provides a staffing mix that is consistent with the resident's assessed care and safety needs, to be implemented voluntarily.

WN #3: 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 :

The licensee has failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

An anonymous complaint was received on a specified date, indicating the residents were not receiving their baths due to staffing shortages and due to a bath and a shower on specified floors, that were not working. The complainant identified two residents that were not receiving their baths which included resident #010 and #011.

Related to resident #010:

Review of the written plan of care (on a specified date) for resident #010 indicated the resident required specified assistance with bathing and preferred a bath or shower twice weekly.

During an interview with resident #010, they indicated that they prefer two baths per week, on specified days and shifts. The resident indicated they were frequently not getting their baths when the bath tub was broken and was not happy about it.

During an interview with PSW #109, they indicated that resident #010 required two staff assistance with bathing and preferred two baths per week, on specified days and shifts.

Review of the point of care (POC) for resident #010 related to bathing provided during a specified period, indicated the resident did not receive a number of their scheduled baths during that period. There was no documented evidence in the residents progress notes to indicate why the bath was not provided.

The licensee had failed to ensure that resident #010 received their minimum of two baths per week, as per their preference.

2. Related to resident #011:

An anonymous complaint was received on a specified date, indicating that resident #011 was not receiving their baths due to a broken tub for a number of weeks.

Review of the written plan of care (on a specified date) for resident #011 related to bathing indicated, the resident required specified assistance with bathing and preferred

to have two baths per week. Review of the bath list indicated the resident was to be bathed on specified days and shifts.

During an interview with PSW #109, they indicated that resident #011 required specified assistance with bathing and preferred a bath twice a week on specified days and shifts.

Review of the point of care (POC) for resident #011 related to bathing provided during a specified period, indicated the resident did not receive a number of their scheduled baths during that period.There was no documented evidence in the residents progress notes to indicate why the bath was not provided.

During an interview with resident #011, they indicated they preferred a tub bath twice a week on specified days and shifts. The resident indicated they frequently do not receive their bath and indicated they did not receive their most recent bath and the bath was not rescheduled. The resident indicated the tub was broken for quite a while and the staff were supposed to take them to another unit but never occurred. The resident was not happy about the lack of bathing that was provided.

The licensee had failed to ensure that resident #011 received their minimum of two baths per week, as per their preference.

3. Related to resident #008:

A complaint was received by the family of resident #008 regarding the resident not receiving their two scheduled baths per week as per the scheduled days and shifts. The family indicated the resident had been told they will get their bath on the next scheduled bath day, when they are missed but did not occur and identified a specified date when the bath was not provided despite a number of complaints from the resident.

During an interview with resident #008, they indicated their preference was to have a tub bath twice a week on specified days and times. The resident indicated that they missed their bath recent bath and was told by staff that they did not have time and would reschedule their bath the following day but the bath was never provided. The resident indicated PSW #114 was supposed to provide their bath. The resident indicated they frequently miss one of their scheduled bath days due to lack of staffing and was an ongoing issue with missed baths.

Review of the current written plan of care (on a specified date) for resident #008 related

to bathing indicated, the resident preferred a tub bath twice a week.
Review of the current bath list indicated resident #008 was to receive their bath on specified days and shifts.

Review of the point of care (POC) for resident #008 under bathing during a specified period, indicated the resident missed a number of their scheduled baths. . There was no documented evidence in the residents progress notes to indicate why the bath was not provided.

During an interview with PSW #114, they indicated that resident #008 was to receive two baths per week on specified days and shifts. The PSW confirmed the resident was not provided their most recent scheduled bath and had not yet been rescheduled. The PSW confirmed they did not inform the charge nurse that the bath for resident #008 was not provided.

During an interview with the acting DOC, they indicated awareness of receiving complaints from families regarding the baths not being provided to residents due to a specified bath tub being out of service and due to ongoing issues with short staffing of PSWs. The acting DOC indicated the tub was out of service for a number of weeks and was not aware that the tub was actually out of service for a number of months. The acting DOC was also unaware that during the same time, a specified shower was also out of service for a number of weeks. The acting DOC indicated they directed the staff to either offer residents a bed bath, a shower or take them to a different tub for bathing. The acting DOC indicated the expectation was that when staff were unable to provide the resident with their bath on the scheduled bath day, they were to be provided either the next shift or the next day. The acting DOC indicated they initiated a bathing audit on a specified date as a result of the complaints they received of baths not being provided. The acting DOC indicated the audit was monitored to determine when baths were not being provided and the home was actively recruiting to fill a number of PSW vacancies.

The licensee failed to ensure that resident #008 was bathed, at a minimum of twice a week.

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 residents are bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #4: 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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

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 :

The licensee has failed to ensure that procedures were developed and implemented for cleaning of the home, including, common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

An anonymous complaint was received on a specified date and indicated concerns related to the cleanliness of the home.

Observation of the second and third floor common areas (hallways, area in front of nursing stations, shower and tub rooms) on a number of identified dates and times by the Inspector, indicated the floors throughout those areas were heavily soiled with dirt. Observation of the floors, especially around the nursing stations, tub and shower rooms on both the second and third floors, were noted to be heavily soiled. The hallways on the second floor were also noted to be heavily soiled around the edges of the halls and at the entrances to the hallways. Observation of the elevator also had soiled areas on walls, doors and the floor.

During an interview with Housekeeper (HSK) #110, they indicated they worked alternately on both the second and third floor but was assigned to housekeeping on the third floor today. The HSK indicated they wash all the floors in the hallways, common areas, tub and shower rooms, including in front of the nursing stations with a dry mop and then with a wet mop with floor cleaner. The HSK indicated that the hallways in front of the resident rooms on the third floor were deep cleaned recently but not sure of the date. The HSK confirmed the floors in front of the nursing station and in the tub/shower rooms required deep cleaning and were heavily soiled. The HSK indicated the floors around the nursing stations on both floors should be deep cleaned more frequently as they are high traffic areas where the residents generally sit and congregate and was unaware when the floors were to be deep cleaned.

During an interview with the Environmental Services Manager (ESM), they indicated that there was a deep cleaning schedule in place for the floors, which included stripping and waxing the floors. The ESM indicated the floors in the hallways and all common areas were deep cleaned approximately one to two times per year. The ESM then toured the home with the Inspector and confirmed the floors in hallways on the second floor, and areas around the nursing stations on both floors, all tub and shower rooms on both the second and third floor were heavily soiled. The ESM was unable to provide documented evidence when the common areas/hallways/shower/tubs rooms on both floors were last deep cleaned or when the next deep cleaning was scheduled.

The ESM provided the Inspector with a procedure for deep cleaning and a schedule that only included resident rooms.

During an interview with the Executive Director (ED), they confirmed awareness that the floors throughout the home were heavily soiled in all common areas, including hallways, tub and shower rooms and was noted when they first arrived in the home as the ED on a specified date. The ED indicated they toured the home with the ESM at that time and

asked the ESM to put a plan in place to rectify this. The ED indicated no awareness that there was no schedule in place for deep cleaning of all floors in common areas, including hallways, tub/shower rooms, around nursing stations and in dining rooms. The ED provided the Inspector with an Environmental Action Plan that was to be put in place on a specified date and confirmed the action plan had not yet been implemented.

The licensee had failed to ensure that procedures were developed and implemented for cleaning of the home, including, common areas, floors as the hallways, tub/shower rooms and elevator were noted to be heavily soiled.

2. The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

An anonymous complaint was received on a specified date and indicated concerns related to the cleanliness of the home.

During a tour of the home on two identified dates and at various times, related to cleanliness of the home, the Inspector noted a lingering offensive odour of urine coming out of an identified resident room. The odour was strongest in the bathroom area. Several of the flooring tiles had large cracked areas at the entrance to the bathroom and rust appearing around the base of the toilet.

Review of the home's policy "Odours" (HL-05-01-06) last revised February 2019, indicated the manager or designate:
1. Investigate the source of the odour and it is recommended that Appendix 1-Odour Control Investigation Tool be used as a guide to identify or make appropriate referrals. All staff are to immediately report any lingering odour to the Support Services Manager/Designate.

During an interview with Housekeeper (HSK) #110, they indicated awareness of a specified resident room having a lingering offensive odour from the bathroom and indicated they try to clean it but the urine is in the floor and the floor needs to be replaced. The HSK indicated the ESM was aware.

During an interview with the Environmental Services Manager (ESM), they indicated they were unaware of a lingering offensive odour in a specified resident room. The ESM then toured the specified resident room with the Inspector and confirmed there was a lingering offensive odour of urine and that the floors and walls outside of the bathroom were in

need of repair and replacement. The ESM confirmed there was no odour control investigation tool received for this room.

During an interview with the ED, they indicated no awareness of lingering offensive odour in a specified resident room and the expectation was that the odours would have been dealt with by housekeeping and the ESM.

The licensee had failed to ensure that housekeeping procedures were developed and implemented for addressing incidents of lingering offensive odours.

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 procedures were developed and implemented for cleaning of the home, including, common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces, to be implemented voluntarily.

Issued on this 9th day of January, 2020

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

Original report signed by the inspector.