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
Mar 5, 2021	2021_815623_0006	016061-20, 000697-21	Critical Incident System

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

SARAH GILLIS (623)

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): February 16-19, 22 and 23, 2021

The following intakes were inspected concurrently:
Two Critical Incident Reports for a fall resulting in a fracture.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Director of Informatics - IPAC Lead, the Medical Director, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeepers, and residents.

The Inspector also reviewed the licensee's internal records, resident health care records, applicable policies, observed the delivery of resident care and services, including staff to resident interactions. A review of the Infection Prevention and Control Program (IPAC) for the home was also completed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care for resident's #001, #003 and #004

was based on an assessment of the residents and the needs and preferences of the residents, related to the use of a specified treatment.

During an interview resident #001 indicated to the Inspector that they were happy to "finally have their treatment back". The resident indicated that during the COVID-19 outbreak in the home, their treatment was not permitted to be used. The resident stated that they were "fearful" and that they told management they needed to have the treatment and were refused.

During an interview, resident #003 also expressed anger and fear, when their treatment was not permitted during the outbreak. The resident indicated that they expressed to the DOC that they wanted the treatment and they were told that they could not have it while the home was in outbreak.

Review of the clinical records for resident's #001, #003 and #004 indicated that all three residents had a specific diagnosis and were prescribed specific treatment. The progress notes indicated that on a specific date the SDM for resident #001 and #004 were notified of the decision to suspend the treatment, both SDM's expressed concerns regarding the suspension of the treatment and consented to a trial for a specified period of time. There was no documentation to indicate that resident #003's SDM was notified. There was no documented evidence of follow-up with the SDM's when the treatment was held beyond the specified time. The clinical records indicate the treatment was suspended for 40 days, for resident #001 and 45 days, for resident's #003 and #004.

During an interview the Director of Care (DOC) indicated that the treatment was placed on hold to prevent the possibility of the effects of the treatment increasing the spread of COVID-19 in the home during the outbreak. The DOC confirmed that there were three residents in total who were affected by this, resident #001, #003 and #004. The DOC indicated that the residents and/or their SDM's were notified of this decision and the decision was made in collaboration with the Medical Director.

During an interview the Medical Director confirmed that they were consulted by the DOC regarding the suspension of the treatment during the COVID-19 outbreak and they were in agreement this was the best approach. The Medical Director indicated they did not discuss this with the residents or their SDM's.

The licensee failed to ensure that the plan of care for resident's #001, #003 and #004 was based on an assessment of the resident and the needs and preferences related to a

specific treatment being provided.

Sources: Interviews resident #001 and #003, DOC and Medical Director. Resident records: Care plan, progress notes, Treatment Records (eTAR). [s. 6. (2)]

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 by ensuring that the plan of care is based on an assessment of the resident and the needs and preferences of the residents, to be implemented voluntarily.

WN #2: 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 :

The licensee 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).

During the tour of the home there were three resident rooms identified as requiring droplet and contact precautions as per the sign on the bedroom door. The PPE cart outside of two of three rooms did not contain masks. Staff were observed to enter the room and don the proper PPE. Upon exit the staff removed all PPE except for their shield and mask. The shield was cleaned and reapplied, the mask was not changed. The signage on the door indicated to remove all PPE when doffing, with an Asterix on the mask identifying to refer to the Universal PPE Strategy.

The long-term care home’s IPAC program included requirements for staff to wear a gown, gloves, eye protection and a mask when providing direct care to a resident on

contact and droplet precautions. The program specified that PPE worn in the room of a resident on contact precautions was to be removed when staff exited the room. Hand hygiene would be required after removal of the PPE.

The document Extendicare COVID-19 Universal PPE Strategy (last reviewed January 2021) Appendix 1 was reviewed by the Inspector.

The Ministry of Health Guidance for mask use in long- term care homes and retirement homes Version 1 – April 15, 2020 was reviewed by the Inspector and indicated the following:

Masks used for source control can be used continuously for repeated close contact encounters who are not in isolation, without being removed between resident interactions and provided they do not need to be disposed of.
Masks used as PPE - for providing direct care where there is a risk of contamination - should be changed as part of routine doffing procedures. However, when cohorting measures have been implemented, the same mask can be used across several resident interactions within the ‘cohort’ (e.g., if all COVID-19 confirmed positive cases are grouped geographically together within a home as indicated by public health; staff work only with COVID-19 positive OR negative residents) and provided the mask does not need to be disposed of between interactions.

A mask must be disposed of if:
•it becomes visibly soiled,
•it makes contact with the resident or their droplets/ secretions (unanticipated),
•it becomes very moist such that the integrity becomes compromised, or
•it is being changed as part of doffing of PPE after a resident engagement, or care is completed to a cohorted group (i.e., those in Droplet/ Contact Precautions).

During an interview RN #104 indicated that staff are instructed to maintain the same mask throughout their shift unless it becomes visibly soiled or wet. The RN indicated this includes when providing care to a resident in contact/droplet isolation. The RN indicated staff are directed to maintain their mask and clean their shield after exiting the isolation room. The RN indicated that the three rooms which require isolation are not cohorted and the staff are also providing care to residents who are not in isolation.

During an interview RPN #102 indicated that all staff who are entering an isolation room with contact/droplet precautions, are asked to clean their shield when they come out and

it is okay to keep their mask on as it is shielded by the shield and would not be considered contaminated. The RPN indicated this is an Extendicare Policy for COVID-19 Universal PPE Strategy to conserve the use of PPE. There was no signage outside of the isolation rooms to indicate staff were to clean their shields.

All staff failed to participate in the implementation of the IPAC program by not changing their mask upon exit from an identified isolation room, which presented actual risk of infection to all residents.

Sources: Observations of isolation rooms, interviews with RN #104 and RPN #102, signage on bedroom door of isolation rooms, the home's policy Extendicare COVID-19 Universal PPE Strategy (last reviewed January 2021) Appendix 1, The Ministry of Health Guidance for mask use in long- term care homes and retirement homes Version 1 – April 15, 2020. [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 by ensuring that all staff participate in the implementation of the Infection Prevention and Control program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 82. Attending physician or RN (EC)

Specifically failed to comply with the following:

s. 82. (4) The licensee shall enter into the appropriate written agreement under section 83 or 84 with every physician or registered nurse in the extended class retained or appointed under subsection (2) or (3). O. Reg. 79/10, s. 82 (4).

Findings/Faits saillants :

The licensee failed to ensure that they entered into a written agreement with the Attending Physician #111 for the home.

During a review of the resident's clinical records it was identified that attending physician #111 had not signed off on telephone/verbal orders for an identified period of time, and progress notes had also not been updated. Inspector requested a copy of the Attending Physician Agreement from the Executive Director. A copy of an agreement was provided, the agreement was expired.

During an interview the Executive Director (ED) confirmed there was not a current attending physician agreement on file in the home for physician #111. The ED indicated that physician #111 was assigned as the primary physician for specific identified residents. During an interview with the Medical Director, they confirmed being aware there was not a current Attending Physician Agreement for physician #111.

The licensee failed to ensure that they entered into an appropriate written agreement under O. Reg. 79/10, s. 83 with physician #111 who was retained to provide services in the home as an attending physician.

Sources: review of resident records and attending physician agreement, interview with Executive Director and Medical Director. [s. 82. (4)]

Issued on this 8th day of March, 2021

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

Original report signed by the inspector.