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
Nov 19, 2021	2021_946111_0004	008367-21, 010153-21, 013519-21, 016515-21	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

LYNDA BROWN (111)

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): October 14, 18 to 20, 2021.

The following inspections were completed concurrently during this inspection:
-Follow up related to plan of care.
-Two critical incidents related to resident to resident abuse.
-One critical incident related to a communicable disease outbreak.

During the course of the inspection, the inspector(s) spoke with Administrator, Acting DOC/Director of Clinical Support, Region Consultant IPAC specialist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Environmental Services Manager (ESM), Housekeepers (HSK) and residents.

During the course of the inspection, the inspector(s): toured the home, reviewed resident health records, observed a dining service, reviewed COVID-19 screening and testing protocols, and reviewed the following policies: Zero Tolerance of resident abuse and neglect and Infection Prevention and Control.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2021_598570_0016	111

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 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 :

The licensee has failed to ensure that any policy instituted or otherwise put in place was complied with related to Infection, Prevention and Control.

The nursing staff were to record daily, any symptoms of infection as part of the surveillance program, including room numbers, in order to determine the possible presence of a communicable disease outbreak. The Infection Control Professional/ Designate was to review and analyze the daily surveillance each day, to determine a potential outbreak and was required to notify Public Health. The daily surveillance did not identify all symptoms displayed by resident #002, #003 and #005 and did not include their room numbers, as per the policy. PH reported that they had not been contacted by the home until a number of days later of a suspected outbreak. Failing to follow IPAC policies can lead to trends of suspected outbreaks unidentified, delayed notification of outbreaks to Public Health and further spread of transmission of infections in the home.

Sources: progress notes of resident #002, #003 and #005, Public Health Line Listing and interview of staff and PHU.

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 where the licensee is 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 (b) is complied, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

There were a number of resident to resident abuse incidents and/or altercations that occurred involving resident #007, towards resident #006, #008 and #012 during a specified period of time, some that resulted in an injury. The plan of care indicated that all incidents involving resident #007 were to be documented in the residents health record. There was no documented evidence of one of the incidents in resident #007's health record. Actions were not taken to prevent a recurrence until an abuse incident that occurred towards resident #008. A known trigger for resident #007 was not addressed to prevent altercations and increased monitoring was not implemented until after a repeated altercation with resident #012. Failing to take steps of identifying and implementing interventions can lead to further risk of altercations and potentially harmful interactions between residents.

Sources: observations and interviews with resident #006, #007 and #008, review of progress notes for resident #006, #007, #008 and #012, care plan, BAT, DOS and PASE consultations for resident #007 and interview of staff.

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 steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

The licensee has failed to ensure that procedures were developed and implemented for cleaning of the home, including resident room and common area floors.

During a tour of the home, the Inspector noted there was heavy soiling of the floors to specified areas throughout the home. The Environmental Service Manager (ESM) indicated that housekeeping was responsible to strip and wax the floors annually to remove the heavy soiling and was aware the floors were heavily soiled. The ESM indicated the first and second floors had been completed in 2021 but was unable to indicate when the floors had been cleaned and confirmed they had no procedures or schedules in place for deep cleaning of the floors. Housekeeping staff confirmed only one specified area had the floors deep cleaned in 2021. Failing to clean the floors throughout the home, can impact the health and well-being of residents.

Sources: observations and interview of staff.

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 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, to be implemented voluntarily.

WN #4: 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. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

The licensee has failed to ensure that staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Documentation of residents with symptoms of infection and on isolation were to be completed on every shift. The home was declared in outbreak on a specified date by Public Health. A number of residents that had demonstrated symptoms of an infection, did not have monitoring of symptoms recorded on each shift as required. Failing to monitor symptoms of infection in residents on every shift in accordance with evidence-based practices, may lead to progression of symptoms undetected and unnecessary isolation of residents.

Sources: progress notes of a number of residents, Public Health Line Listing and interview of staff.

Issued on this 22nd day of November, 2021

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

Original report signed by the inspector.