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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: July 10, 2024

Inspection Number: 2024-1138-0002

Inspection Type:
Proactive Compliance Inspection

Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)

Long Term Care Home and City: Port Perry Place, Port Perry

Lead Inspector	**Inspector Digital Signature**
Julie Dunn (706026)	Julie Dunn Digitally signed by Julie Dunn Date: 2024.07.15 15:07:24 -04'00'

Additional Inspector(s)
Sheri Williams (741748)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 27 - 31 and June 3 - 5, 2024.

The following intake(s) were inspected:

- Intake: #00116877 - Proactive Compliance Inspection (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
Pain Management
Falls Prevention and Management

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)
Non-compliance with: O. Reg. 246/22, s. 267 (2) (a)
Visitor policy
s. 267 (2) Every licensee of a long-term care home shall maintain visitor logs for a minimum of 30 days which include, at a minimum,
(a) the name and contact information of the visitor;

Non-compliance with O. Reg. 246/22 s. 267 (2) (a)
The licensee failed to ensure that the visitor sign-in books for the LTC home included collection of contact information for visitors.

Rationale and Summary

On entering the long-term care home for a Proactive Compliance Inspection (PCI), it was observed that the visitor sign-in book included designated spaces for visitors to enter the date, name of visitor, name of the resident they were visiting, reason for visiting, and the time entering and leaving the LTC home. The information collected did not include any contact information for the visitors to the LTC home.

In an interview, the director of care (DOC) acknowledged there was no collection of visitor contact information in the visitor sign-in books as per regulation requirement, indicated that the front desk staff oversaw the visitor sign-in books, and that they would take steps to resolve the issue immediately.

The following day, the DOC provided an updated visitor sign-in log. On review, it was observed that the updated visitor sign-in pages included a field that was added to collect visitors' phone numbers or email addresses.

Sources: Observations, Visitor sign-in books, interview with DOC.
[706026]

Date Remedy Implemented: May 28, 2024

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care

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,

(b) the resident's care needs change or care set out in the plan was no longer necessary.

The licensee failed to ensure that the plan of care for a resident was reviewed and revised when their care needs changed, or care set out in the plan was no longer necessary.

Rationale and Summary
The plan of care for a resident specified their care needs related to transfers, positioning and safety.

During two observations of the resident, the devices specified in the resident's plan of care for transfers, positioning and safety were not in use.

A personal support worker (PSW) indicated that the resident's transfer needs had changed, and that the resident no longer required the safety device. The PSW also indicated that when specific devices were not available, they used a substitute device instead.

The Director of Care (DOC) acknowledged the expectation of the home was for the plan of care to be kept up to date and provide clear directions to staff.

Failing to update the plan of care for the resident when their care needs changed posed a low risk that the resident would not have their care needs met.

Sources: Resident clinical records, observations, and interviews with staff. [741748]

WRITTEN NOTIFICATION: Home to be safe, secure environment

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 5

Home to be safe, secure environment

s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee failed to ensure that the home was a safe and secure environment for its residents.

Rationale and Summary

During a tour of a resident home area for the Proactive Compliance inspection (PCI), Inspector observed a hallway to the side of the nursing station covered by a curtain. Beyond the curtain was the tub and shower area covered with a curtain. Inside the tub room was observed sharps containers on the counter and the floor, with a disposable razor on the counter. The tub room also had a wall mounted chemical disinfectant. The doors within the area were unlocked and unsupervised by staff.

During a tour of a second resident home area, it was observed that the tub and shower area had a door that was not fully closed and was not locked or supervised. Signage posted on the door directed staff to keep the door closed due to resident safety. Inside this area was a door with a sign saying Nursing supplies. There were nursing supplies including razors and shaving cream, and the door was not fully shut.

On a subsequent day, it was again observed in the second resident home area that the door to the tub and shower area was unlocked and unsupervised. The door to the Nursing supplies room within this area was observed to be not fully closed or

locked, Inside the Nursing supplies room were various nursing supplies, including razors and prescription topical shampoo for several residents.

The Director of Care (DOC) acknowledged that the items found within the tub and shower areas could pose a safety risk to residents.

Failing to ensure the home was a safe and secure area posed a risk to resident safety.

Sources: Observations, Interview with DOC. [741748]

WRITTEN NOTIFICATION: Communication and response system

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (a)
Communication and response system
s. 20. 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;

s. 20. (a) The licensee failed to ensure that the resident-staff communication and response system could be easily accessed and used by a resident at all times.

Summary and Rationale
During a PCI, a resident was observed on two occasions without access to their call bell. On both occasions, the resident was seated in a chair in their room, and the call bell was inaccessible to the resident.

When asked by the inspector how they asked for assistance if they needed it, the resident indicated they just wait, or they yell.

The care plan indicated a safety risk for the resident and indicated the call bell was to be within easy reach.

In an interview, a registered practical nurse (RPN) indicated that the call bell needed to be in reach for the resident and that they would put in a request to ask for a longer call bell cord for the resident. The DOC indicated that there were different types of call bells, including call bells with longer cords, and that the expectation was for the call bell to be placed by the resident.

Failing to ensure that the call bell could be easily accessed and used by the resident placed the resident at risk of not having their personal needs met or possibly sustaining an injury by attempting to complete a task on their own for which they required staff assistance.

Sources: observations, resident clinical records, interviews with staff and resident. [706026]

WRITTEN NOTIFICATION: Air temperature

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee failed to ensure that the air temperatures in the long-term care home were consistently measured and documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Summary and Rationale
Air temperature logs were requested and provided during a Proactive Compliance Inspection. The logs showed air temperatures were recorded only once daily, at 0800 hours, on several dates in a specified month, and there were no afternoon nor evening temperatures recorded. There were no air temperatures recorded in the long-term care home's air temperature logs on a specified date.

The Daily Data Report from Environment Canada for the specified month showed the daily maximum outside temperature for the area of the long-term care home exceeded 26 degrees Celsius on several days of the month.

In an interview, a staff member indicated they were not aware that it was required for the air temperatures to be documented at three different times of day, that they had been informed of the requirement and would do so going forward.

Failing to consistently measure and record the air temperatures in the long-term care home on days when the outside temperature exceeded 26 degrees Celsius increased the risk of heat exposure for residents.

Sources: LTC Home Air Temperature Logs, Environment Canada Daily Data Report, Interview with staff. [706026]

WRITTEN NOTIFICATION: Quarterly Evaluation

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)
Quarterly evaluation
s. 124 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator,

the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 246/22, s. 124 (1).

The licensee has failed to ensure that the Medical Director was included in the interdisciplinary team which met quarterly to evaluate the effectiveness of the medication management system in the home.

Rationale and Summary
During the PCI, the home was asked to provide a copy of their quarterly medication evaluation and it indicated that the Medical Director was absent.

A review of the Continuous Quality Improvement Committee, where the medication evaluation was also reviewed, indicated that the Medical Director was absent from it as well.

The DOC acknowledged that the Medical Director did not participate in the Quarterly evaluation of the medication management system in the home.

Failing to ensure that the quarterly evaluation included the Medical Director, posed a risk to the home that the medication management system evaluation did not include input from the Medical Director.

Sources: Quarterly Evaluation of the home's medication management system and interview with the DOC. [741748]

WRITTEN NOTIFICATION: Annual Evaluation

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 125 (1)
Annual evaluation
s. 125 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The licensee has failed to ensure that an interdisciplinary team, which must include a Registered Dietitian who was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Rationale and Summary:
During the PCI, the home was asked to provide a copy of their annual medication evaluation and it indicated that the Registered Dietician (RD) was absent.

The DOC acknowledged that the RD did not participate in the Annual evaluation of the medication management system in the home.

By failing to have an annual interdisciplinary review of the home's medication management system that includes all required participants this posed a risk of changes and improvements not being implemented as required.

Sources: Annual Evaluation of the home's medication management system and interview with the DOC. [741748]

WRITTEN NOTIFICATION: Safe Storage of Drugs

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

Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

Safe storage of drugs

s. 138 (1) Every licensee of a long-term care home shall ensure that,

(a) drugs are stored in an area or a medication cart,

(ii) that is secure and locked.

The licensee failed to ensure that medications for seven residents were stored in an area that was secured and locked.

Rationale and Summary

During a PCI, topical medication containers with prescription labels for seven different residents were observed in an unlocked incontinence product supply room.

The home's medication storage policy directs that medications were to be stored in a secure and locked area that was exclusively used for storage of medication related supplies.

Two PSWs indicated that the resident's topical medications were stored in the unlocked room so they could access them to apply to the residents.

The DOC acknowledged that it was the expectation of the home that all medications were to be kept locked and secured in a medication room or cart.

Failing to ensure that medications for seven residents were stored in a secure area posed a risk to residents that they could consume or use the medications unsafely.

Sources: Observations in home, Policy "Medication Storage Areas", interviews with staff. [741748]

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

Infection prevention and control program

s. 102 (2) The licensee shall implement,

(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1) The IPAC Lead or management designate will provide education for all PSW and RPN staff in a specified resident home area on the importance of supporting hand hygiene for residents prior to meals and snacks.

2) Keep a written record of the education provided, the dates the training occurred, the names of the staff members who attended, and the name of the person who provided the training.

3) The Infection Prevention and Control (IPAC) lead is to train up a designate charge nurse on the resident hand hygiene auditing process. Keep a written record of the training, the content of the training, the dates the training occurred, the names of the attendees, and the name of the person who provided the training. The IPAC Lead or trained designated charge nurse will complete meal or snack time resident hand hygiene audits three times a week for 4 weeks in the specified resident home area. Over the course of the four-week period the audits will include all three mealtimes and the afternoon snack service time, choosing only one meal or snack time per

audit. Documentation will include the name of the person completing the audit, the meal or snack service time, the name and job category of the staff that were observed, whether the resident hand hygiene was performed correctly, or missed, and any on-the-spot re-education provided, if necessary. Two PSWs will attend a hand hygiene audit for one meal service, alongside the IPAC Lead or trained designate charge nurse. They will participate in making observations alongside the trained auditor but are not required to fill out an audit tool. They must take part in a debrief discussion regarding the audit findings and any corrective actions that were taken. A summary of the debrief discussion will be kept, including participant names, date, and time, and be made available to Inspectors, immediately upon request.
4) All hand hygiene audits will be retained for records and made available to Inspectors, immediately upon request.

Grounds
The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented. According to O. Reg 246/22 s. 102 (2) (b), the licensee shall implement any standard or protocol issued by the Director with respect to IPAC.

Rationale and Summary
The IPAC Standard for Long-Term Care Homes, revised September 2023, s. 10.2 (c) stated the hand hygiene program for residents shall include assistance to residents to perform hand hygiene before meals and snacks.

During a PCI, observations were completed prior to and during lunch and afternoon snack service in a resident home area. Residents were not consistently supported in performing hand hygiene prior to being served lunch options that included hand-held sandwiches on multiple dates. During an afternoon snack observation, there

was no resident hand hygiene observed and there was no alcohol-based hand rub on the snack cart. A PSW provided beverages and hand-held brownies as snacks for the residents. The PSW confirmed they did not assist the residents with hand hygiene prior to providing the snacks, and that they would usually use hygiene wipes to assist residents with hand hygiene prior to snacks.

In an interview the IPAC Lead indicated that the expectation was for residents to be supported with hand hygiene using alcohol-based hand rub or Sani-Hands prior to meals and snacks.

Failing to support residents in the performance of hand hygiene prior to meals and snacks placed the residents at increased risk of exposure to infectious agents.

Sources: Observations, interviews with staff.
[706026]

This order must be complied with by September 18, 2024.

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor

Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.