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 West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: August 21, 2024

Inspection Number: 2024-1081-0003

Inspection Type:
Complaint
Critical Incident

Licensee: CVH (No. 8) 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: Errinrung Long Term Care Home, Thornbury

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 6 - 9,12 -15, 2024

The following intake(s) were inspected:

- Intake: #00117657 - CI #2513-000006-24 - related to Medication Management
- Intake: #00118178 - Complaint - related to multiple environmental concerns and cares
- Intake: #00120896 - CI #2513-000013-24 related to Infection Prevention and Control

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

Resident Care and Support Services
Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: specific duties re cleanliness and repair

NC #001 Written Notification pursuant to FLTCA 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that.
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

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

Rationale and Summary

During a tour of the home, the following observations were made:

Approximately 5 bed systems were overly noisy when raised or lowered.

Casement windows in resident rooms and end of hallway missing a lock and/or unable to open or close. On the exterior, the caulking around these casement windows were dried out and receded.

Accumulation of dust in exhaust fan grilles and in exhaust fan motors located in resident washrooms.

Soiled utility rooms included utility sinks with plastic bags over them. Staff had previously used the sinks for rinsing soiled linens. No specific plans provided regarding how these spaces will be utilized.

Exhaust motor in shower room not functional.

Self closing device on an entrance/exit door was not properly adjusted and it slammed shut when released. The door was in a state that could cause an injury.

The automatic door opening buttons were not functional as the entry/exit door. Residents in wheelchairs were not able to enter or exit independently.

Loose screw noted on the door striker plate at the main entry/exit door.

The transition from the wood deck outside the main entry door was reported by residents who used wheelchairs to be difficult to glide over.

Missing light pulls for many lights mounted over resident beds.

Light bulbs burnt out or the ballast was not functional on many overbed lights in resident bedrooms. An identified resident indicated that a family member had to bring in a lamp for their use as the light had been out for many months.

Stained ceiling tiles in resident washrooms.

Cracked lenses noted for light fixtures. A light fixture with fluorescent tubes was missing a lens cover. The light over the vanity in the area was flickering. A light in a soiled utility room took 2 minutes to turn on.

Five resident washroom sinks noted to have many hairline cracks around the drain.

A tub room did not have a functional exhaust fan in the washroom area. A grille in the ceiling was blowing air into the space.

Tub room had an electric heater that was severely rusted with sharp edges.

Pull cord for call station in dining room in older section of the building was missing. Station was located almost 6 feet above the floor and could not be reached by residents in wheelchairs.

A servery had what appeared to be mould on the wall board near the base of the wall. Flooring was partially completed, and the cabinetry door was missing. A servery had floor tiles missing.

Wood deck had a piece of planking that was raised behind the entrance door to the area. A downspout was sitting with the opening directly onto the wood planking of the deck. A large area of the deck was covered in a black substance.

Several outdoor chairs were rusted with holes through the chrome legs.

The hand wash sink in the laundry room did not have hot running water. The hot water faucet spun around 360 degrees.

The Whirlpool washing machine, used regularly by laundry staff was out of order. The machine was identified to be a beneficial part of the day-to-day laundering process.

Privacy curtain tracks and sliders for the hooks were not easy to maneuver. The sliders got stuck in the tracks and were found to be broken and without hooks. Some curtains were not attached to the hooks.

A section of the wood handrail was loose next to an exit.

The licensee hired a new Environmental Services Manager (ESM) on June 11. 2024, who was still learning about their role and the maintenance program at the time of inspection. The previous ESM left their position on June 12, 2024. The corporate Fire, Life and Safety and Environmental Consultant attended the home beginning mid June for several weeks to assist the ESM with completing maintenance tasks.

Although policies and procedures were developed for routine, remedial and preventive maintenance, their implementation was questionable based on the

condition of the home. With respect to preventative maintenance routines for the home, an annual resident room audit form was provided, but no date or auditor name was included. Some notes that were included on the back of the form, identified that some painting and repairs were completed in two resident rooms. No common area audits were available for review. An external building checklist was last completed in January 2023. No routine or regular audits were completed. The remedial maintenance program consisted of an electronic process, whereby staff entered requests into a software program and maintenance staff responded.

Corporate consultants audited the home during the week of July 29th and discovered many of the same issues noted above. A plan of action was reviewed with the consultants, which included time frames for addressing most of the issues noted above.

Failure to implement and comply with the maintenance program schedules and procedures has created adverse conditions in the home which does not align with the fundamental principle under the Fixing Long Term Care Act to promote high quality accommodation to live in a safe and comfortable environment.

Sources: Observations, interview with the Fire, Life and Safety and Environmental Consultant. Clinical Consultant and review of maintenance policies and procedures and audits.

WRITTEN NOTIFICATION: Privacy curtains

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: 0. Reg. 246/22, s. 16
Privacy curtains
s. 16. Every licensee of a long-term care home shall ensure that every resident

bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

The licensee has failed to ensure that every resident bedroom occupied by more than one resident had sufficient privacy curtains to provide privacy.

Rationale and Summary

A complaint was received by a resident that they did not have sufficient privacy around their bed in a semi-private room. A tour of the home revealed that numerous rooms did not have privacy curtains installed to offer adequate privacy. Privacy curtains did not spread out from track end to track end when pulled. In some cases, there was a shortage of at least 24 inches of curtain. In other cases, the curtains did not have the ability to stay closed either because the affixed Velcro tabs were no longer effective, or there were tabs missing.

Sources: Observations, discussion with the Environmental Services Manager and Fire, Life and Safety and Environmental Consultant.

WRITTEN NOTIFICATION: Communication and response system

NC #003 Written Notification pursuant to FLTCA 2021. s.154 (1) 1.
Non-compliance with: 0. Reg. 246/22, s. 20 (e)
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
(e) is available in every area accessible by residents;

The licensee has failed to ensure that the home was equipped with a resident-staff

communication and response system that was available in every area accessible by residents, specifically, the outdoor patio.

Rationale and Summary

The outdoor patio, which included two levels, an upper deck and a lower patio area with tables and chairs did not include a call station for staff, resident or visitor use to alert staff when required.

Sources: Observations, interview with the Environmental Services Manager and the corporate Fire, Life and Safety and Environmental Consultant.

WRITTEN NOTIFICATION: 24-hour admission care plan

NC #004 Written Notification pursuant to FLTCA 2021. s.154 (1) 1.
Non-compliance with: 0. Reg. 246/22, s. 27 (4)
24-hour admission care plan
s. 27 (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment. reassessments and information provided by the placement coordinator under section 51 of the Act. 0. Reg. 246/22, s. 27 (4).

The licensee has failed to ensure that the care set out in the care plan was based on an assessment of the resident and the needs and preferences of that resident.

Rationale and Summary

A resident was admitted to the home as part of a short-stay respite care program. The resident spoke with staff on the first day of admission and requested bed rails

so that they could re-position themselves when in bed for independence. The resident was informed about the risks associated with the bed rails, and that they were not normally permitted. The staff stated that they would pass along their request to another staff member on a different shift. However, no follow up occurred with the resident and no documentation was made by any staff as to whether the resident would receive an assessment for bed rail use or otherwise. The resident stated that no staff member assessed them for bed mobility or initiated the process to have bed rails added to their bed. A staff member confirmed that the home had quarter bed rails available for resident use once assessed.

Staff reported that they initiated the installment of a transfer device near their bed within an hour of the resident's admission. The resident reported that the device was not of any benefit to them for bed re-positioning. The transfer device was not added to their plan of care and was not identified as required on their MDS Physical Functioning Assessment. The resident was upset that they had to use their call station to summon a personal support worker to their bed each time they needed to be repositioned.

Failure to assess the resident based on their needs and preferences resulted in a diminishment of their independence.

Sources: Review of the resident's care plan, assessments and Bed Rail Safety Policy, and interviews with the resident and home's staff.

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA 2021, s. 154 (1) 1.
Non-compliance with: 0. Reg. 246/22, s. 54 (3)
Falls prevention and management

s. 54 (3) Every licensee of a long-term care home shall ensure that the equipment. supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. 0. Reg. 246/22, s. 54 (3).

The licensee has failed to ensure that falls prevention equipment. or devices were readily available at the home.

Rationale and Summary

A resident complained that they did not feel secure in using a grab bar that was installed next to a toilet they were using. They reported that their hand had slipped down the length of the bar. The bar was observed to resemble a towel bar, as it was thin, long and was not slip resistant. Only certain resident washrooms had this type of bar, whereas others had grab bars that were thicker and had a slip resistant etching on the surface.

Failure to install appropriate falls prevention devices or equipment increases the risk of resident falls.

Sources: Observations, interview with the resident. and Corporate Clinical Consultant.

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #006 Written Notification pursuant to FLTCA 2021. s. 154 (1) 1.
Non-compliance with: 0. 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. 0. Reg. 246/22, s. 102 (2).

The licensee failed to implement. Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, last revised September 2023, when staff did not complete hand hygiene prior to and during meal service.

Rationale and Summary

In accordance with Routine Practices and Additional Precautions Requirements in the IPAC Standard section 9.1(b) At minimum Routine Practices shall include: Hand hygiene, including, but not limited to, at the four moments of hand hygiene (before initial resident/resident environment contact when staff did not complete hand hygiene prior to and during meal service.

The home's Hand Hygiene policy directed staff to complete hand hygiene between direct contact with residents, before preparing, handling, serving food or medications or feeding a resident and after touching any high-touch surfaces such as keyboards, doorknobs, elevator buttons.

A staff member did not perform **HH** while transporting residents to the dining room.
A staff member did not perform **HH** while serving from the beverage cart and distributing drinks and applying clothing protectors for residents.
A staff member did not perform **HH** while taking meal orders and serving meals to residents.
A staff member did not perform HH while delivering soup to tables at lunch meal.

Staff members stated that hand hygiene should be performed between transporting residents, after clearing dirty dishes, prior to serving food, and before assisting residents to eat.

When staff did not complete hand hygiene there was an increased risk of transmitting infectious agents.

Sources: Inspector observations, home's policy, Interview with staff members.

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #007 Written Notification pursuant to FLTCA 2021. s.154 (1) 1.
Non-compliance with: 0. Reg. 246/22, s. 147 (2) (c)
Medication incidents and adverse drug reactions
s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that.
(c) a written record is kept of everything required under clauses (a) and (b). 0. Reg. 66/23, s. 30.

The licensee failed to ensure that a medication incident report was documented when Glucagon was administered.

Rationale and Summary

A resident was administered Glucagon.

The home's policy stated the nurse was to complete a report on all events of severe hypoglycemia, unresponsive hypoglycemia and events that required the administration of Glucagon tracked.

A medication incident report was not documented when Glucagon was administered.

Staff stated they did not complete a medication incident report when Glucagon was administered.

When a medication incident report is not documented, as required, there may be a delayed response in changes and improvements related to resident safety and use of Glucagon.

Sources: Policy RC-24-01-02: Diabetes Management - Hypoglycemia, Medication incident report interviews with staff.

COMPLIANCE ORDER CO #001 Doors in a home

NC #008 Compliance Order pursuant to FLTCA 2021. s.154 (1) 2.
Non-compliance with: 0. Reg. 246/22, s. 12 (1) 1. iii.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident. including balconies and terraces, or doors that residents do not have access to must be,
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with 0. Reg. 246/22, s. 12 (1) 1. iii. [FLTCA, 2021, s. 155 (1) Cb)]:

Please submit the written plan for achieving compliance for inspection #2024-1081-0003 to MLTC, by email to centralwestdistrict.mltc@ontario.ca by September 6, 2024.
Please ensure that the submitted written plan does not contain any PI/PHI.

The plan must include but is not limited to:

1. Specify what work is necessary to ensure that stairwell doors, and access doors into and out of the long-term care home, are equipped with an audible door alarm installed at each door: and
2. Specify what work is necessary to ensure that the audio component of the door alarm is separate and distinct from other alarms and produces a sound to alert staff working within the vicinity of the door.
3. Include the name of the contractor who will be conducting the repair, amendment or upgrades to the system and the date the work is expected to be completed.

Grounds

The licensee has failed to ensure that the following rule was complied with:

All doors leading to stairways, and doors leading to unsecured outside areas of the home must be equipped with an audible door alarm that allows calls to be cancelled only at the point of activation.

Rationale and Summary

When tested, stairwell doors, and both access doors into and out of the long-term care home, all of which were accessible to residents, did not have an audible door alarm installed at each door. No alarm sounded when doors were held open for over one minute.

Failure to ensure that all stairwell doors and doors leading to unsecured outdoor areas of the home are equipped with an audible door alarm increases the risk of residents eloping when staff are not alerted to doors that are not closed and locked.

Sources: Observations, interview with the Environmental Services Manager, and the corporate Fire, Life and Safety and Environmental Consultant.

This order must be complied with by

December 31. 2024

COMPLIANCE ORDER CO #002 Doors in a home

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

Non-compliance with: 0. Reg. 246/22, s. 12 (1) 1. iii. B.

Doors in a home

s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1 All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident. including balconies and terraces, or doors that residents do not have access to must be,

iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

B. is connected to an audio-visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with 0. Reg. 246/22, s. 12 (1) 1. iii. B. [FLTCA, 2021, s. 155 (1) (b)I:

Please submit the written plan for achieving compliance for inspection #2024-1081-0003 to MLTC, by email to centralwestdistrict.mltc@ontario.ca by September 6, 2024.

Please ensure that the submitted written plan does not contain any PI/PHI.

The plan must include but is not limited to:

1. Specify what work is necessary to ensure that stairwell doors, and both access doors into and out of the long-term care home, will be connected to the resident-staff communication and response system or to the closest enunciator panel located at a nursing station: and
2. Specify what work is necessary to ensure that the audio component sounds throughout the corridors so that staff can hear the alert when working in different areas of the home.
3. Include the name of the contractor who will be conducting the repair, amendment or upgrades to the system and the date the work is expected to be completed.

Grounds

The licensee has failed to ensure that the following rule was complied with:

All doors leading to stairways, and doors leading to unsecured outside areas of the home must be connected to an audio-visual enunciator that is connected to the nurses' station nearest to the door.

Rationale and Summary

When tested, stairwell doors, and access doors into and out of the long-term care home, all of which were accessible to residents, were not connected to the enunciator panels located at the nursing stations closest to the door tested. The enunciators did not sound or visually indicate the location of the breached door when held open.

Failure to ensure that all stairwell doors and doors leading to unsecured outdoor areas of the home are connected to the enunciators increases the risk of residents eloping when staff are not alerted to doors that are not closed and locked.

Sources: Observations, interview with the Environmental Services Manager and the corporate Fire, Life and Safety and Environmental Consultant.

This order must be complied with by

December 31, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICEThe 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.