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: 2024-1029-0001
Inspection Type: Proactive Compliance Inspection
Licensee: CVH (No. 2) 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: Parkview Manor Health Care Centre, Chesley

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 16-19, 22- 25, 30-31, 2024 and August 1, 2024
The inspection occurred offsite on the following date(s): July 24, 29-31, 2024
The following intake(s) were inspected:

- Intake: #00121147 related to Proactive Compliance Inspection

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

Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Quality Improvement
Pain Management
Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Infection Prevention and Control

Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Residents' Rights and Choices

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: FLTCA, 2021, s. 85 (3) (r)
Posting of information
s. 85 (3) The required information for the purposes of subsections (1) and (2) is,
(r) an explanation of the protections afforded under section 30; and

The Licensee has failed to ensure that an explanation of the Whistle Blowing Protection was posted in the home that complies with the requirements established by regulations.

Rational and summary
The Long-Term Home Care (LTCH) Inspector and the Director of Care were not able to locate the Whistle Blowing Protection information posted in the home.

The Administrator confirmed that it was not posted earlier but had been posted after the LTCH inspector made the licensee aware.

Sources: Observation of the postings in the home, interview with PSW #104 and

#105, Director of Care and Administrator.

Date Remedy Implemented: July 19, 2024

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (1)
Continuous quality improvement initiative report
s. 168 (1) Every licensee of a long-term care home shall prepare a report on the continuous quality improvement initiative for the home for each fiscal year no later than three months after the end of the fiscal year and, subject to section 271, shall publish a copy of each report on its website.

Rationale and Summary
The licensee failed to publish Continuous Quality Improvement Initiative report on there website for the year 2024.

The CQI Initiative report was not posted to the home's website.

The CQI Initiative report was published on their website after the LTCH inspector made the licensee aware.

Sources: Website of LTCH, email from ED and Interview with DOC.

Date Remedy Implemented: July 26, 2024

WRITTEN NOTIFICATION: Duty of licensee to consult Councils

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 73
Duty of licensee to consult Councils
s. 73. A licensee has a duty to consult regularly with the Residents' Council, and with

the Family Council, if any, and in any case shall consult with them at least every three months.

The licensee has failed to consult regularly with the Family Council at least every three months.

Rational and summary
The home was to conduct quarterly Family Council/Town Hall meetings. However, a review of the Family Council/Town Hall meeting minutes revealed that the meetings were not held every three months.

The Administrator acknowledged non-compliance with quarterly meetings due to lack of retaining a consistent program manager.

There was a risk of delayed or missed communication with the Family Council when Town Hall meetings were not conducted every three months.

Sources: Observation of the Family and Resident Council board in the home, review of family council, town hall meeting minutes, interview with administrator.

WRITTEN NOTIFICATION: General requirements

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who

participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee failed to keep a written record relating to the pain management program evaluation under paragraph 3 that includes the date of the evaluation and a summary of the changes made and the date that those changes were implemented.

Rationale and Summary
During the record review of the home's pain management program evaluation, the LTCH Inspector noted that the pain management program evaluation did not include the date when the evaluation was completed and summary of changes made during the evaluation and the date that those changes were implemented.

Failure to document the summary of changes during the pain management evaluation, may make it difficult to monitor the progress and changes to the program.

Sources: Pain management program evaluation and Interview with DOC.

WRITTEN NOTIFICATION: Nursing and personal support services

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (4)
Nursing and personal support services
s. 35 (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee failed to keep a written record of staffing plan evaluation under clause

(3) (e) that includes the date of the evaluation and a summary of the changes made and the date that those changes were implemented.

Rationale and Summary
During the record review, the LTCH Inspector noted that the staffing plan evaluation did not include the date of the evaluation and summary of changes made and the date that those changes were implemented.

Sources: Staffing Plan Evaluation record and Interview with ED.

WRITTEN NOTIFICATION: Bathing

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (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 their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that resident was bathed, at a minimum, twice a week by the method of their choice.

Rational and summary
A review of the resident's bathing record noted that they did not receive regular baths at least twice per week, they did not receive a shower or bath on their scheduled days regularly and nor were they offered a shower or bath on an alternative day.

The Administrator stated that bathing was listed PRN "as needed" instead of twice per week, resulting in missed baths.

Failure to offer the resident baths at minimum twice per week put the resident at risk of not meeting their hygiene needs.

Sources: Observation and clinical record review of resident, interview with PSW, RN and other staff.

WRITTEN NOTIFICATION: Nail care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 39 (2)
Foot care and nail care
s. 39 (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails.

The licensee has failed to ensure that resident received fingernail care.

Rational and summary
The LTCH Inspector noted the concerns with resident's fingernails.

A residents fingernails were not trimmed as per their plan of care.

An Registered Nurse (RN) observed the resident's fingernails and agreed that they required trimming.

Failure to offer fingernail care to the resident put the resident at risk of not meeting their hygiene needs.

Sources: Observation and clinical record review of resident, interview with PSW, RN and other staff.

WRITTEN NOTIFICATION: Menu planning

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (3)
Menu planning
s. 77 (3) The licensee shall ensure that a written record is kept of the evaluation under clause (2) (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that the changes were implemented. O. Reg. 246/22, s. 390 (1).

The licensee failed to ensure that a written record was kept of the menu cycle evaluation that included the names of the persons who participated in the evaluation.

Rationale and Summary
Registered Dietitian (RD) and Food Service Manager (FSM) evaluated the home's 2024 spring-summer menu cycle prior to it being in effect.

The home's menu evaluation and approval record for the 2024 spring-summer menu cycle was signed off by RD however, the name and signature of FSM were not documented.

Sources: Spring 2024 Menu Evaluation & Approval Record; Interviews with RD and FSM.

WRITTEN NOTIFICATION: Dining and snack service

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a

dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee failed to follow their process for ensuring that food being served was at a temperature that is both safe and palatable to the residents.

Rationale and Summary
According to the Temperature of Food at Point of Service Policy, "Dietary staff shall serve food and beverages to each resident at a temperature and in a manner that promote comfort and safety".

The LTCH Inspector reviewed the temperature log of items served at lunch time. There was missing temperature documentation of desert.

Dietary Aid (DA) stated they did not take the temperature and served it at room temperature.

The Food Service Manager (FSM) stated that the DA was expected to check and document the temperature of the item at the time of serving it to the residents to ensure its safe and plateable. Additionally they said canned desert are expected to be served chilled not at room temperature.

Failure to check and document the temperature of food items means staff were not aware of whether the temperature was not safe or palatable for residents.

Sources: Record review of temperature log and Food Service Manual; and interview with Dietary Aid and Food Service Manager.

WRITTEN NOTIFICATION: Housekeeping

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The license failed to ensure that procedures for cleaning and disinfecting of a resident care equipment between resident use were implemented.

Rationale and Summary
According to the Cleaning and Disinfecting Equipment policy, shared resident care equipment (i.e. tub chairs/shower chairs/commodes/lifts, etc.) must be cleaned and disinfected after each use by registered and direct care staff.

Two staff members used a resident care equipment on a resident. Afterwards the staff members proceeded to use the equipment on another resident across the hall. The equipment was not cleaned or disinfected by staff members in between the two resident uses.

Sources: Lift Transfer Observations; Cleaning and Disinfecting Equipment policy; and interviews with Personal Support Worker (PSW) , Infection Prevention and Control (IPAC) Lead and Director of Care (DOC).

WRITTEN NOTIFICATION: Infection prevention and control program

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed by staff.

Specifically, additional requirement under 9.1 the IPAC Standard states that the licensee shall ensure that hand hygiene, including, but not limited to, at the four moments of hand hygiene before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact) were followed.

Rational and Summary
According to home's meal services and dining experience policy, "Staff ensure to wash/sanitize their hand before starting meal services, before feeding a resident, and after handling soiled dishes"

The Personal Support Worker (PSW) was assisting residents in the dining room at lunch time. The PSW did not perform hand hygiene after removing the soiled dishes and before serving desert to the residents.

IPAC Lead stated that PSW should have performed hand hygiene after removing the dirty dishes and before serving the desert to the residents.

Sources: Meal service Observation; Interviews with PSW and IPAC Lead and Homes Meal service and Dining experience Policy.

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 1.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

The licensee has failed to ensure that drugs that are to be destroyed shall be stored safely and securely within the home until the destruction and disposal occurs.

Rational and summary
As per the Medication Destruction and Disposal – non-Narcotic/Controlled medication Policy (Revised June 30, 2023), staff were to store the disposed medication in an area where only nurses have access.

The LTCH Inspector noted that non controlled drugs were put in a medication disposal container provided by the pharmacy. This container was kept in an unlocked nursing station where residents and visitors had access.

Failure to store the medication to be destroyed safely and securely increased the risk of residents and visitors having access to them.

Sources: Observation of drug disposal and destruction areas, interview with RN and DOC, Medication Destruction and Disposal – (non-Narcotic/Controlled medication Policy (Revised June 30, 2023).

WRITTEN NOTIFICATION: Drug destruction and disposal

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 148 (2) 2.
Drug destruction and disposal
s. 148 (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

The licensee has failed to ensure any controlled substance that were to be destroyed and disposed of shall be stored in a double-locked storage area within the home until the destruction and disposal occurs.

Rational and summary
According to the home's Destruction and Disposal of Narcotic and Controlled Medications Policy, the narcotics were to placed in a container with one way opening prior to destruction.

The LTCH Inspector noted that disposed controlled substances were placed in a locked container inside a locked cabinet; however, the opening of the container was not equipped with one way opening allowing for the drugs to be taken out of the container by hand easily.

Failure to dispose the controlled substances in a container with one way opening increased the risk of non authorized persons access to the disposed controlled substances.

Sources: Observation of drug disposal and destruction areas, interview with RN and

DOC.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 1.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
1. The name and position of the designated lead for the continuous quality improvement initiative.

The licensee failed to include the name and position of the designated Continuous Quality Improvement lead in the Continuous quality improvement initiative report.

Rationale and Summary
The Director of Care (DOC) acknowledge that the Continuous Quality Improvement (CQI) report was missing the name and position of the CQI lead.

Sources: CQI report 2024 and Interview with DOC

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (2) 5. iii.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:

5. A written record of,
iii. how, and the dates when, the results of the survey taken during the fiscal year under section 43 of the Act were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee failed to include the dates in the Continuous Quality Improvement (CQI) Initiative report for the year 2024 of when the results of the resident experience survey and family experience survey taken in October 2023 were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

Rationale and Summary
The Continuous Quality Improvement (CQI) Initiative report for the year 2024 did not includes dates of when the results were communicated to the residents and their families, Residents' Council, Family Council, if any, and members of the staff of the home.

Sources: CQI report and Interview DOC.

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee failed to ensure that a copy of the Continuous Quality Improvement Initiative (CQI) report is provided to the Residents' Council and Family Council.

Rationale and Summary
The Executive Director (ED) stated that a copy of the CQI report was not provided to resident council or to the families during the family town hall or via email.

Sources: Email from ED and Interview with ED.

COMPLIANCE ORDER CO #001 Windows

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 19
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimeters.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:
The Licensee shall prepare, submit, and implement a plan to achieve compliance with the requirement under O Reg 246/22, s. 19 Windows safety for resident #009.

The plan shall include but is not limited to:

1. Steps that will be taken as permanent measures to ensure resident 's window does not open more than 15 centimeters (cm).
2. Identifying when and how the nursing staff will monitor the window, including how they will document this. Also, how they will inform maintenance staff if there is an issue and how and where maintenance staff will document their follow up.
3. Identifying the responsibilities of the interdisciplinary team, including the environmental services manager, in ensuring the window is secure and cannot open more than 15 cm.

Please submit the written plan for achieving compliance for inspection #2024-1029-0001 to Gurvarinder Brar (000687), LTC Homes Inspector, MLTC, by email to centralwestdistrict.mltc@ontario.ca by September05, 2024.
Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds
The Licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents cannot be opened more than 15 centimeters (cm).

Rational and Summary
The LTCH Inspector noted that resident vertical sliding window opened completely and more than fifteen centimeters (cm). The LTCH Inspector reported this to the Director of Care, who stated that they would have the window fixed to open no more than 15 cm.

The LTCH Inspector observed the window open more than 15 cm again.

The Administrator stated that the maintenance staff fixed the window, but the screws were removed again.

The resident's plan of care had a specific intervention in place related to window safety however it was unclear whether staff were implementing the intervention. Additional measures were implemented. The Administrator stated that these interventions were in place as a temporary measure and they were reaching out to their clinical consultant to come up with a permanent solution.

Failure to ensure the windows do not open more than 15 cm put the resident's safety at risk.

Sources:

Review of resident clinical record, Resident bedroom window observations, interview with PSW, laundry staff, RN, Director of Care and Administrator.

This order must be complied with by September 26, 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:

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

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.