Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Apr 18, 2019	2019_640601_0007	012299-18, 013123-18, 018745-18, 028743-18	Complaint

Licensee/Titulaire de permis

CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Warkworth Place
97 Mill Street P.O. Box 68 Warkworth ON K0K 3K0

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

KARYN WOOD (601), LAURIE MORRISON (747)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 12, 13, 14, 15, 18, 20, 21, 22, 25 and 26, 2019.

Complaint log #012299-18 related to insufficient staffing and care.

Complaint log #013123-18 related to insufficient staffing and care.

Complaint log #018745-18 related to the temperature in the home, insufficient staffing and care.

Complaint log #028743-18 related to allegations of neglect, agency staff not being trained properly, insufficient staffing and care.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC), Office Manager (OM), Registered Nurses (RN), RAI Coordinator (RAI/RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Occupational Therapist (OT), Acting Program Director (APD), Personal Support Workers (PSW), Behavioural Support Ontario (RPN/BSO), Housekeeping Aide, (HA), family members and residents.

The inspectors also reviewed residents' health care records, the licensee's relevant policies and procedures, maintenance records and observed the delivery of resident care and services, including resident-staff interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Falls Prevention
Family Council
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **4 WN(s)**
- **4 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in the plan regarding three identified interventions for falls prevention and skin integrity.

Record review of resident #001's current care plan by Inspector #601, identified that the resident was at risk for falls and the interventions included a falls prevention device.

On a specified date and time, Inspector #601 and Inspector #747 observed that resident #001 did not have their identified falls prevention device in place.

During separate interviews on two specified dates, RN #107 and PSW #142 indicated to Inspector #601 that resident #001 was required to have their identified falls prevention device in place.

On two specified dates and times, Inspector #601 observed that resident #001 did not have their identified intervention for skin integrity in place.

Record review of resident #001's current care plan by Inspector #601, identified that the resident #001 had planned interventions to maintain skin integrity.

During separate interviews on two identified dates, PSW #150 and PSW #142 indicated to Inspector #601 that resident #001 was required to have their identified intervention in place during a specified time to maintain skin integrity.

During an interview on two identified dates, RN #107 indicated to Inspector #601 that resident #001 was required to have their identified intervention in place during a specified time to maintain skin integrity. RN #107 further indicated that they would put a reminder in the communication book for staff, as a reminder to use the resident's identified

intervention.

On a specified date and time, Inspector #601 and Inspector #747 observed that resident #001 did not have their second falls prevention device in place.

Record review of resident #001's current care plan by Inspector #601, identified that resident #001 had a planned intervention for another specified falls prevention device.

During an interview on a specified date and time, PSW #142 indicated to Inspector #601 and Inspector #747 that they had been using resident #001's identified falls prevention device for meals. PSW #142 further indicated that the Director of Care (DOC) had informed them prior to the interview with the inspectors that resident #001's care plan had been changed and that resident #001 was required to have their identified falls prevention device in place whenever the resident was out of bed.

During an interview on a specified date, the DOC indicated to Inspector #601 that resident #001's SDMs had requested that the resident have their identified falls prevention device in place whenever the resident was out of bed.

The licensee did not ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in the plan regarding three identified interventions for falls prevention and skin integrity. [s. 6. (7)]

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 the care set out in the plan of care for resident #001 is provided to the resident as specified in the plan regarding three identified interventions for falls prevention and skin integrity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that actions were taken with respect to resident #001 under the falls prevention and management program, including assessments, reassessments, interventions and that the resident's responses to interventions were documented following the fall.

Related to Long-Term Care Home (LTCH) complaint log #028743-18:

Record review of resident #001's Falls Management-Post Fall Assessment by Inspector #601, identified that the resident had fallen on a specified date and time and the resident sustained an identified injury.

Inspector #601 reviewed the licensee's Falls Prevention and Management Program, RC-15-01-01, the procedures required for 72 hours post-fall included that the following steps were to be taken:

1. Assess the following at each shift:

a) Pain;
b) Bruising;
c) Change in functional status;
d) Change in cognitive status;
e) Changes in range of motion.

2. Communicate resident status at end of each shift. Communicate new falls, falls injuries, flagged residents and precautionary measures at daily clinical meeting.

3. Notify the Physician or Nurse Practitioner if there is a sudden change in vital signs and/or neurological assessment, or if the resident:

a) Becomes increasingly restless, irritable or confused;
b) Is nauseated or vomits;
c) Displays abnormal shaking movement or has a seizure;
d) Complains of dizziness and/or visual disturbance;
e) Has gradually increasing blood pressure, either systolic or diastolic and/or complains of a severe headache;
f) Has progressive weakness or paralysis of extremities;
g) Has an elevated temperature;
h) Develops a stiff neck;
i) Cannot be easily roused.

4. Document the fall and results of all assessments and actions taken during the 72 hour post-fall follow-up.

5. Initiate Post Fall Investigation, if clinically indicated.

6. Refer to Restorative Care Program, Physiotherapy (PT) or Occupational Therapy (OT), Dietitian, Housekeeping, Maintenance and other members of interdisciplinary team for follow up, as appropriate.

7. Update interdisciplinary care plan in collaboration with resident and family or Substitute Decision Maker (SDM). Obtain consent to changes from resident or SDM. Communicate care plan to all staff.

Record review of resident #001's progress notes indicated the following documentation was completed for 72 hours post-fall:

Day one
-On a specified date at an identified time, a post fall assessment was completed by RPN #109, the resident's pulse, blood pressure and an identified injury was documented.
-On a specified date at an identified time, RPN #109 documented that resident #001 was administered an identified analgesic, as per request for complaints of discomfort to their identified areas due to their fall.

Day two
-On a specified date at an identified time, the DOC documented that resident #001's SDM requested to have an identified medication for responsive behaviours reduced and to closely monitor the resident's responsive behaviours. The Physician was faxed with an

update.
-On a specified date at an identified time, Agency RPN #113 documented an assessment of the resident's condition.
-On a specified date at an identified time, the Agency Nurse documented resident remains on bed rest during the morning hours, sleeping, easily aroused and taking fluids well.
-On a specified date at an identified time, the DOC documented that the Physician had reduced the resident's identified medication for responsive behaviours.

Record review of resident #001's Minimum Data Set (MDS) Fall Resident Assessment Protocol (RAP) with a specified date after the resident had fallen identified that resident #001 had a specified decreased mobility over the past week and that the resident required a specified mobility aid.

During an interview on a specified date, RAI/RN #151 indicated to Inspector #601 and Inspector #747 that resident #001's health condition had declined gradually. RAI/RN #151 also indicated that a referral to PT was not required at the time of the MDS Fall RAP was completed. RAI/RN #151 further indicated that on a specified date, there was a resident care team review for resident #001 and it was identified that there was potential discomfort due to identified observations of the resident. According to RAI/RN #151, that following the care team review an identified analgesic was initiated twice daily for resident #001.

Record review of resident #001's Physician Orders on a specified date, identified that the resident had been prescribed a specific type of mobility aid, as needed for a specified reason. The Physician also prescribed an identified analgesic two tablets twice a day.

During an interview on a specified date, the DOC indicated to Inspector #601 and Inspector #747 that the licensee's Falls Prevention and Management Program, RC-15-01 -01, was in place when resident #001 had fallen on a specified date. According to the DOC, the registered staff were required to document their assessments of resident #001 in the Post Fall Assessment and in the resident's progress notes for 72 hours following the fall. The DOC also indicated that resident #001 had an identified responsive behaviour and the analgesic had been prescribed to manage the behaviours and that a clinical pain assessment was not completed. According to the DOC, resident #001 had a specified decline in mobility and the specific type of mobility aid was brought in by resident #001's SDMs. The DOC further indicated that they were not aware of any referrals to the PT or OT following the resident's fall or when the specific type of mobility

aid was initiated, on a specified date.

The licensee did not ensure that actions were taken with respect to resident #001 under the falls prevention and management program, including assessments, reassessments, interventions and that the resident's responses to interventions were documented following the fall on a specified date. [s. 30. (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 to ensure that actions are taken with respect to resident #001 under the falls prevention and management program, including assessments, reassessments, interventions and that the resident's responses to interventions are documented following a fall, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with the residents' assessed care and safety needs and that the back-up plan for nursing and personal care staffing addressed situations when staff who provide nursing coverage cannot come to work.

The Ministry of Health and Long Term-Care information line received three separate anonymous complaints related to concerns about insufficient staffing in the home, residents not receiving their scheduled baths and that resident safety was being compromised due to the staff not being replaced for sick calls. The Long-Term Care Home (LTCH) also submitted to the Director a complaint letter and the response provided to the Complainant regarding a written complaint to the licensee about insufficient staffing, care standards and the residents scheduled baths not being provided.

Related to complaint log(s) #012299-18, log #013123-18, log #018745-18 and log #028743-18:

Record review of the licensee's Master Rotation for Staff by Inspector #601, identified the following:

-Total number of RNs: five full-time and three part-time;
-Total number of RPNs: one full-time and three part-time;
-Total number of PSWs: eighteen full-time and fifteen part-time;
-Behavioural Support Ontario (BSO), RPN: one full-time;
-Quality Control, RPN: one full-time.

Record review of the licensee's Rotation Schedule for Registered staff and PSWs by Inspector #601, identified the following number of staff on days, evenings and nights:

Day shift:
-Two RNs;
-One RPN;
-Six PSWs;
-One Behavioural Support Ontario (BSO), RPN;
-One Quality Control, RPN.

-One RN;
-One RPN;
-Six PSWs.

Night shift:
-One RN;
-Two PSWs.

Record review of the PSW daily assignment, by Inspector #601 identified that there was a total of sixty residents residing in the home. The PSW work load assignments were divided into the following six sections:

-Section one with ten residents;
-Section two with ten residents;
-Section three with eleven residents;
-Section four with ten residents;
-Section five with nine residents;
-Section six with ten residents.

Record review of Plan B, Short-Handed, by Inspector #601 when one PSW was not able to work. The back-up plan was to dissolve section six and the PSWs work load assignments were divided into the following five sections:

-Section one with twelve residents;
-Section two with twelve residents;
-Section three with eleven residents;
-Section four with thirteen residents;
-Section five with twelve residents.

Related to resident #001:

Inspector #601 reviewed the PSWs Rotation Schedule and the Point of Care (POC) Documentation Survey Report for resident #001 for a specified period. Resident #001's bath was scheduled on the specified shift, twice a week.

Record review of resident #001's Point of Care (POC) Documentation Survey Report for a specified period, by Inspector #601 identified that there was no documentation to indicate that resident #001 had received their scheduled bath on a number of identified

dates or that the resident was provided with an alternate bath.

Record review of the PSWs Rotation Schedule for a specified period, by Inspector #601 identified that the full complement of PSW's was not in place as per the staffing plan, on a number of identified dates when resident #001 did not receive their scheduled bath.

Related to resident #005:

Inspector #601 reviewed the PSWs Rotation Schedule and the Point of Care (POC) Documentation Survey Report for resident #005 for a specified period. Resident #005's bath was scheduled on the specified shift, twice a week.

Record review of resident #005's Point of Care (POC) Documentation Survey Report for a specified period, by Inspector #601 identified that there was no documentation to indicate that resident #005 had received their scheduled bath on a number of identified dates or that resident #005 was provided with an alternate bath.

Record review of the PSWs Rotation Schedule for a specified period, by Inspector #601 identified that the full complement of PSW's was not in place as per the staffing plan, on a number of identified dates when resident #005 did not receive their scheduled bath.

Related to resident #007:

Inspector #601 reviewed the PSWs Rotation Schedule and the Point of Care (POC) Documentation Survey Report for resident #007 for a specified period. Resident #007's bath was scheduled on the specified shift, twice a week.

Record review of resident #007's Point of Care (POC) Documentation Survey Report for a specified period, by Inspector #601 identified that there was no documentation to indicate that resident #007 had received their scheduled bath on a number of identified dates or that resident #007 was provided with an alternate bath.

Record review of the PSWs Rotation Schedule for a specified period, by Inspector #601 identified that the full complement of PSW's was not in place as per the staffing plan, on a number of identified dates when resident #007 did not receive their scheduled bath.

During separate interviews on two identified dates, PSW #136, PSW #142, PSW #150 and RN #118 indicated to Inspector #601, that the PSW staffing plan was for two PSWs

to work nights and six PSWs worked on days and evenings. The staff further indicated that there should be three staff on each side during the days and evenings. The staff interviewed indicated that when there were five staff working they would have two PSWs on each side, work in pairs and one PSW would work on both sides. The staff further indicated that if they had four PSW's working then they would have two PSWs working each side. According to the staff interviewed, they did work with less than six PSWs at times and the resident's scheduled baths were not always completed or provided with an alternate bath.

During separate interview on two identified dates, the Executive Director (ED) and Director of Care (DOC) indicated to Inspector #601 that recruitment for PSWs had been ongoing and there had been times when the licensee's staffing plan was not followed due to PSWs not being able to come to work. They both indicated that there had been a shortage of PSWs during the summer of 2018 and that recruitment efforts had improved. They both indicated that the staffing back-up plan had been developed for when one PSW was not able to come to work. The staffing back-up plan involved the six sections being divided into five. The ED also indicated that there was no written back-up plan for when more than one PSWs was not able to come to work. The ED further indicated that when the PSW staff was not at full complement, the laundry, dietary and activity aides would assist the PSW's with their workload. According to the ED, laundry aides would put away the residents personal clothing, housekeeping aides would assist by making resident beds and dietary staff would assist by feeding residents, at meal time. The ED further indicated that the housekeeping and dietary aides had also been trained to be the second person during resident transfers with the mechanical lift.

The licensee did not ensure that resident #001, #005 and #007 received their scheduled bath and that the staffing plan provided for a staffing mix that was consistent with the residents' assessed care and safety needs and that the back-up plan for nursing and personal care staffing that addresses situations when staff who provide nursing coverage cannot come to work. [s. 31. (3)]

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 the staffing plan provides for a staffing mix that is consistent with the residents' assessed care and safety needs and that the back-up plan for nursing and personal care staffing addressed situations when staff who provide nursing coverage cannot come to work, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff applied resident #005's specified device that had been ordered or approved by a physician or registered nurse in the extended class.

Related to Long-Term Care Homes (LTCH) complaint log #028743-18:

Inspector #601 reviewed resident #005's current physician order and identified that on a specified date, resident #005's Physician reviewed the specified device.

On a specified date, Inspector #601 observed resident #005 sitting in a resident common area with their Substitute Decision Maker (SDM). Resident #005 did not have the specified device in place. During an interview, Resident #005's SDM indicated to Inspector #601, they were not aware of the reason resident #005 no longer had the specified device. Resident #005's SDM further indicated that the resident hadn't fallen

recently and that staff will usually call them with updates.

Record review of resident #005's current care plan indicated that the resident was a high risk for falls for specified reasons. The resident was to use the specified device, as per family request.

Record review of resident #005's current care plan interventions included the specified device.

During an interview on an identified date and time, RN #101 and RN #107 indicated to Inspector #601 that resident #005 currently had a Physician's order for the specified device and they were not sure when the specified device was changed. RN #107 further indicated that this could have been reviewed at the weekly care meeting.

During separate interviews on two identified dates, the Acting Program Manager (APM) #102 and the DOC indicated to Inspector #601 that resident #005's specified device was discussed two weeks prior, at the weekly meeting. They both indicated that resident #005 no longer required the specified device and a two week trial was initiated to see how the resident would manage without the specified device. The DOC further indicated that RAI/RN #151 should have contacted the Physician and resident #005's SDM for consent prior to changing resident #005's specified device.

The licensee did not ensure that resident #005's specified device was in place as ordered or approved by a physician or registered nurse in the extended class. [s. 110. (2) 1.]

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 staff apply resident #005's specified device that is ordered or approved by a physician or registered nurse in the extended class, to be implemented voluntarily.

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d’inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 29th day of April, 2019

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

Original report signed by the inspector.