Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Oct 21, 2019	2019_640601_0020	013756-19	Complaint

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

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)

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): September 5, 6, 9, 10, 11, 12, 13, 18, 19 and 20, 2019.

The following intake was inspected during this complaint inspection:

Complaint Log #012703-19 related to staff not being trained properly, insufficient staffing and care standards not being provided for bathing and other care areas.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Behaviour Support Ontario (BSO), RAI-Coordinator (RAI), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Supervisor (FSS), Dietary Aide (DA), Office Manager (OM), Family members and residents.

The inspector also reviewed resident health care records, the licensee's relevant policies and procedures, staffing schedules, observed the delivery of resident care and services, including staff to resident interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Dining Observation
Family Council
Minimizing of Restraining
Personal Support Services
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (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 his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #007, #009, #010 and #012 were bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths.

Review of resident #007's, #009's, #010's and #012's clinical health records related to provision of care specific to bathing was completed by Inspector #601.

Related to resident #007:

Review of resident #007's clinical health record by Inspector #601, identified the resident preferred a tub bath and their bath was scheduled for 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 five identified dates or that the resident was provided with an alternate bath. [s. 33. (1)]

2. Related to resident #009:

Review of resident #009's clinical health record by Inspector #601, identified the resident preferred a tub bath and their bath was scheduled for twice a week.

Record review of resident #009'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 #009 had received their scheduled bath on ten identified dates or that the resident was provided with an alternate bath. [s. 33. (1)]

3. Related to resident #012:

Review of resident #012's clinical health record by Inspector #601, identified the resident preferred a shower and their shower was scheduled for twice a week.

Record review of resident #012'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 #012 had received their scheduled shower on six identified dates or that the resident was provided with an alternate shower. [s. 33. (1)]

4. Related to resident #010:

Review of resident #010's clinical health record by Inspector #601, identified the resident preferred a tub bath and their bath was scheduled for twice a week.

Record review of resident #010'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 #010 had received their scheduled bath on twelve identified dates or that the resident was provided with an alternate bath.

During separate interviews on specified dates, PSW #110, RN #109, PSW #111, RN #106, PSW #112, the Director of Care (DOC) and the Executive Director (ED) indicated to Inspector #601, that PSW staff did work with less staff on the days and evenings shift, at times. They further indicated that when working with less PSWs, the resident's scheduled baths on days and evenings were not always completed and they were not provided with an alternate bath.

The licensee did not ensure that resident #007, #009, #010 and #012 were bathed, at a minimum, twice a week by the method of his or her choice. [s. 33. (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 ensure that all residents are bathed, at a minimum, twice a week by the method of his or her choice, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #007's physical device was applied in accordance with the manufacturer's instructions.

A written complaint was received by the Director on a specified date, from resident #007's Substitute Decision Maker (SDM) regarding an incident that occurred on a specified date, involving resident #007's and their identified physical device.

Record review of resident #007's physical device care plan in place on the specified date identified that resident #007 required the identified physical device and the following interventions were in place:

- Family and MD will sign identified forms as per policies. Identified physical device will be reassessed routinely as per policies;
- Report immediately to registered staff if resident had identified behaviours.

A review of resident #007's progress note on the specified date by Inspector #601, identified that RN #103 documented the resident's identified physical device was broken and a temporary identified device was put into place.

During separate interview on a specified date, PSW #112 and RN #103 indicated to Inspector #601 that resident #007 required the identified physical device, for a specified reason. RN #103 further indicated that resident #007's SDM had reported the incident involving resident #007's identified physical device. RN #103 also indicated that resident #007's identified physical device had broken and it had been determined the identified physical device had not been applied properly by PSW #112, on the specified date

During an interview on a specified date, the Director of Care (DOC) indicated to Inspector #601 that resident #007 required the identified physical device, for a specified reason. The DOC further indicated that on the specified date, resident #007's SDM had reported to RN #103 the incident involving resident #007 and the identified physical device. According to the DOC, RN #103 determined that resident #007's identified physical device was not applied properly by PSW #112, on the specified date.

A review of the licensee's identified policy by Inspector #601, indicated the approved identified physical device will be applied in accordance with manufacturer's specifications and directions.

The licensee did not ensure that resident #007's physical device was applied in accordance with the manufacturer's instructions, on the specified date. [s. 110. (1) 1.]

Issued on this 31st day of October, 2019

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

Original report signed by the inspector.