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 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 25, 2017	2017_623626_0002	003712-17	Complaint

Licensee/Titulaire de permis

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

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

Port Perry Place
15941 Simcoe Street Port Perry ON L9L 1N5

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

DENISE BROWN (626)

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 16 and 17, 2017

1. Complaint

Log #003712-17: Falls; Resident to resident physical abuse; notification and continence.

2. Critical Incidents

Log #001372-17: Related to fall with fracture
Log #003833-17: Related to fall with injury
Log #002112-17: Related to resident to resident physical abuse

During the course of the inspection, the inspector(s) spoke with the acting Director of Care (DOC), MDS-RAI Coordinator-Staff Educator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and the complainant.

During the inspection, the inspector observed the resident home areas, staff to resident provision of care and resident to resident interactions. The inspector reviewed the residents' health records, internal related investigations, applicable policies, related complaint and critical incidents.

The following Polices were reviewed:

Falls Management and Resident Abuse by Persons other than Staff.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

3 WN(s)
2 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	Legendé 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. Every Licensee shall ensure that there is in place a written policy to promote zero tolerance for abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee's policy of Abuse of Resident by Persons other than Staff with policy reference #OPER-02-02-04 and version date of September 2015 outlined the following:

Extendicare is committed to providing a safe and supportive environment in which all residents are ensured dignity and respect. Every person in the home has a mandatory and legal obligation to immediately report suspected or witnessed abuse.

All individuals, (including family members, volunteers, visitors, contracts or any other person) who have reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director (ON) or the governing provincial regulatory body.

During the course of the inspection and after a review of resident #001 health records, it was noted that there was an incident of alleged physical abuse to resident #001, which involved resident #002. The incident occurred on a specified date in 2016. There was no evidence that the incident, which resulted in injury to resident #001 was reported to the Director.

The health records documentation dated on specified date in 2016, by an agency Registered Nurse (RN) #107 indicated, that resident #002 struck resident #001 causing injury to resident #001.

In an interview on a specified date in 2017, Personal Support Worker (PSW) #102 indicated that, there was an incident of alleged physical abuse of resident #001 by resident #002 during a specified month in 2016 but was uncertain of the specific date. The PSW also indicated that the incident occurred in a common area, resident #002 struck resident #001 causing an injury. Resident #002 was receiving additional monitoring at the time of the alleged incident. In another interview on a specified date in 2017, PSW #101 indicated that resident #002 was receiving enhanced monitoring but was unable to indicate the specific time frame.

During an interview on a specified date in 2017, the acting Director of Care (DOC) indicated that resident #002 struck resident #001, causing an injury. The agency nurse on duty RN #107, documented the incident in the health records. The acting DOC was uncertain, if the DOC at the time of the incident was informed. The acting DOC in the same interview, also indicated that there was no evidence that a Risk Management report or Critical Incident Report (CIR) was submitted to notify the Director of the incident.

The licensee failed to ensure that the written policy to promote zero tolerance for abuse and neglect of residents was complied with. Agency nurse RN #107 and PSW #102, did not report the alleged physical abuse by resident #002 to resident #001 causing injury and in doing so, failed to follow the licensee's policy. Subsequently, the incident was not reported to the Director. [s. 20. (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 there is a process in place and monitored, in order to safeguard that the written policy to promote zero tolerance for abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 222. Exemptions, training

Specifically failed to comply with the following:

s. 222. (2) The licensee shall ensure that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing their services. O. Reg. 79/10, s. 222 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that staff who are at the home pursuant to a contract or agreement with the licensee will not provide direct care to residents before receiving the following information, the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports, whistle-blowing protections under section 26, fire prevention and safety, emergency and evacuation procedure and or infection prevention and control, specifically, hand hygiene, modes of infection transmission, cleaning and disinfection practices; and, use of personal protective equipment.

Under O. Reg. 79/10, s. 222 (1) - Subject to subsection (2), a licensee of a long-term care home is exempt from the requirements under section 76 of the Act with respect to persons who, (a) fall under clause (b) or (c) of the definition of staff in subsection 2 (1) of the Act; (b) will only provide occasional maintenance or repair services to the home; and (c) will not provide direct care to residents. Note: The licensee does not meet the exemption as identified in O. Reg. 79/10, s. 222 (1).

Under LTCHA, 2007, s. 76 (1) - Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section.

During the course of the inspection in the home and in reviewing resident #001's health records, it was noted that there was an alleged incident of resident to resident physical abuse resulting in injury to resident #001 by resident #002. The incident occurred on a specified date in 2016 and was not reported to the Director.

The health records documentation dated on a specified date in 2016, by RN #107 who was contracted by the home from a nursing agency, indicated that resident #002 struck resident #001 and the resident sustained an injury.

During an interview on a specified date in 2017, the acting DOC also indicated that

resident #002 struck resident #001, causing an injury. The agency nurse on duty RN #107, documented the incident in the resident's health records. The acting DOC was uncertain, if the DOC at the time of the incident was informed. In the same interview the acting DOC also indicated, that no evidence was found to indicate that a CIR was submitted and the Director informed of the incident.

A review of the licensee's agency education list provided by the MDS-RAI Coordinator and Educator indicated, that RN #107 was not on the list as having received education pertaining to the Licensee's Zero Tolerance of Abuse and Neglect policy and the reporting of Critical Incidents. The MDS-RAI Coordinator and Educator confirmed that RN #107 did not receive this education.

The licensee failed to ensure that staff who are at the home pursuant to a contract or agreement with the licensee, will not provide direct care to residents before receiving the following information, the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, and duty to make mandatory reports. Subsequently, RN #107 did not report to the licensee the alleged resident to resident physical abuse that caused injury to resident #001 and consequently, the incident was not reported to the Director. [s. 222. (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 there is a process in place and monitored, in order to safeguard that the persons described in clauses (1) (a) to (c) are provided with information about the items listed in paragraphs 1, 3, 4, 5, 7, 8 and 9 of subsection 76 (2) of the Act before providing their services, to be implemented voluntarily.

WN #3: 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 failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to falls prevention.

Related to Intake #001372-17, pertaining to resident #001:

A Critical Incident Report (CIR) was submitted to the Director on a specified date in 2017, regarding resident #001's fall, which resulted in injury and transfer to hospital.

According the CIR documentation on a specified date in 2017, the resident was taken from the dining room by PSW #106 and left in another resident area unsupervised. The fall occurred during the time that the resident was left unsupervised. The resident complained of pain in a specified area of the body after the fall and was transferred to hospital. According to the documentation in the resident's health records, resident #001 sustained an injury from the fall.

Resident #001's plan of care indicated a list of interventions for falls prevention specific to the resident's needs.

In an interview with Inspector #626 on a specified date in 2017, Registered Practical Nurse (RPN) #100 indicated that resident #001 was considered at high risk for falls. In an interview on a specified date in 2017, PSW #102 also indicated, that the resident was at high risk for falls and should be monitored at all times. Personal Support Worker #101 in another interview on the same day, also indicated that the resident was at high risk for falls and was to be monitored every 15 minutes.

During an interview with Inspector #626 on a specified date in 2017, the acting DOC indicated that the resident was left in a resident area by the PSW #106 and was not visible to staff when the fall occurred. The acting DOC also indicated in the same interview that resident #001's, plan of care outlined that after meals the resident should have been put to bed.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, related to falls prevention. The PSW did not follow resident #001's plan of care as specified, by not returning the resident to bed after the meal. The resident was left in a resident area out of view of staff, where the fall occurred and the resident sustained an injury. [s. 6. (7)]

2. Related to Intake #002112-17, pertaining to resident #001 and resident #002:

A CIR was submitted to the Director on a specified date in 2017, related to a resident to resident physical abuse that occurred on a specified date in 2017 and from which resident #001 sustained an injury.

The incident occurred on a specified date in 2017, when resident #002 struck resident #001 causing an injury. The incident occurred during the time period, when resident #002 experienced an escalation in responsive behaviours and was receiving additional monitoring. Resident #002 was to be on enhanced supervision during a specified time and was left unsupervised, while the PSW assigned to do the additional monitoring had gone for break.

Resident #002 has an history of identified responsive behaviours. The resident's plan of care indicated a list of intervention to manage the resident's responsive behaviours, which were specific to the resident's needs.

In an interview with Inspector #626 on a specified date in 2017, RPN #100 indicated that resident #002 would exhibit identified responsive behaviours if redirected. The resident was also receiving additional monitoring. In separate interviews on the same date with PSWs #102 and #104, both indicated that resident #002 displayed the same identified responsive behaviours, when redirected and can be resistive to care. The PSWs also indicated in the same interviews that the resident was provided with enhanced monitoring.

During an interview with Inspector #626 on a specified date in 2017, the acting DOC indicated that the PSW who was assigned to the additional monitoring of resident #002, did leave the resident unattended during the period of time in which the incident involving resident #001 occurred.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. The PSW did not follow resident #002's plan of care as

specified by leaving the resident unattended and was not monitoring the resident, as stipulated in the plan of care [s. 6. (7)]

Issued on this 25th day of May, 2017

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

Original report signed by the inspector.