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
Nov 22, 2018	2018_533115_0023	026686-17, 026987-17, 008310-18, 021923-18, 024312-18	Complaint

Licensee/Titulaire de permis

CVH (No. 5) GP Inc. as general partner of CVH (No. 5) 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

Country Village Homes - Woodslee
440 County Road 8, R.R. #2 Woodslee ON N0R 1V0

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

TERRI DALY (115), DEBRA CHURCHER (670)

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): November 5, 6, 7, 8, 9, 13, 14, 15, and 16, 2018

Inspector #739 and Inspector #731 participated in this complaint inspection.

The following complaint inspections were conducted:
Complaint Log #026987-17 / IL-54278-LO related to care and services;
Complaint Log #026686-17 / IL-519474-LO related to care and services;
Complaint Log #024312-18 / IL-59543-LO related to alleged abuse;
Complaint Log #021923-18 / IL-59108-LO / IL-59107-LO related to falls prevention;
Complaint Log #008310-18 / IL-56630-LO / IL-56749-LO related to admission refusal.

During the course of the inspection, the inspector(s) spoke with the Long Term Care Executive Director (ED), the Director of Care (DOC), one Registered Nurse (RN), three Registered Practical Nurses (RPN), a Housekeeping Aide, four Personal Support Workers (PSW), CCAC Case Manager (CM), and family members.

The inspectors also observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home and internal investigative notes.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who exhibited altered skin integrity, including skin tears, were reassessed at least weekly by a member of the registered nursing staff if clinically indicated.

The Ministry of Health and Long-Term Care (MOHLTC) received complaints related to skin and wound care for resident #001 and resident #002.

A complaint was received on a specific date by the Ministry of Health and Long Term Care infoline. The complainant expressed concern related to resident #001's treatment plan.

A review of the clinical record showed that staff completed weekly wound and skin assessments in Point Click Care (PCC) under the assessment tab.

A review of the individual assessments for a specific area of altered skin integrity for resident #001, revealed that a weekly wound and skin assessment was not completed on a number of dates.

A complaint was received on a specific date by the Ministry of Health and Long Term Care infoline. The complainant expressed concern related to resident #002's treatment

of an area of impaired skin integrity.
A review of the weekly wound and skin assessments showed that an assessment was not completed on a specific date.

A review of additional clinical records for a resident with altered skin integrity showed that resident #007 had a specific area of altered skin integrity.
A review of the weekly wound and skin assessments showed that an assessment was not completed on a specific date.

A review of the home's policy Skin and Wound Program: Wound Care Management effective February 2017 under Documentation indicated:
2. Complete the Bates-Jensen Wound Assessment Form for each open area/wound and keep in the treatment binder.
3. Complete the Bates-Jensen Assessment if condition is worsening or not improving as expected, but minimum every 7 days.

An interview with Registered Practical Nurse (RPN) #102, they stated that all registered staff were responsible to ensure weekly wound and skin assessments were completed and documented under the assessment tab in PCC usually on Saturday or Sunday.

The Director of Care (DOC) #101 reviewed the weekly wound and skin assessments for resident #001, resident #002 and resident #007 and indicated that not all assessments were completed weekly, they said that the expectation was that registered staff were to complete the weekly wound and skin assessments in PCC under the assessment tab per the home's policy. [s. 50. (2) (b) (iv)]

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 resident's who exhibit altered skin integrity, including skin tears, are reassessed at least weekly by a member of the registered nursing staff if clinically indicated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

s. 44. (10) The persons referred to in subsection (9) are the following:
1. The applicant. 2007, c. 8, s. 44. (10).
2. The Director. 2007, c. 8, s. 44. (10).
3. The appropriate placement co-ordinator. 2007, c. 8, s. 44. (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that an applicant's admission to the home was approved unless;
a) the home lacked the physical facilities necessary to meet the applicant's care requirements;
(b)the staff of the home lacked the nursing expertise necessary to meet the applicant's care
requirements; or
(c) circumstances existed which were provided for in the regulations as being a ground for withholding approval.

The MOHLTC received a complaint regarding the home refusing admission to resident #003 based on specific reasons.

During an interview with Case Manager (CM) #004, they stated that they were not the CM that was originally managing this application and was covering for the CM that the application was assigned to. CM #004 shared that they had received notification of the bed refusal through the portal used for reviewing applications however this did not

include the rationale for the refusal or a justification for the decision and that no further documentation could be located.

Director of Care (DOC) #101 stated that they were the DOC at the time of the refusal. DOC #101 was unable to locate any documentation within the home related to refusal of admission of resident #003 but stated they were involved and familiar with the refusal. They stated that resident #003 was refused admission based on certain behaviours. DOC #101 acknowledged that the home received funding from the LHIN's for Behavior Supports Ontario (BSO), had an internal BSO team, and that all staff members were trained regarding behavior management and Gentle Persuasive Approaches. DOC #101 indicated that the home had utilized one to one staffing for residents in the past related to behavioral issues. The DOC also noted that this was their first time refusing admission to a resident and acknowledged that the home should not have refused admission to the resident.

The licensee has failed to ensure that an applicant's admission to the home was approved unless;
a) the home lacked the physical facilities necessary to meet the applicant's care requirements;
(b)the staff of the home lacked the nursing expertise necessary to meet the applicant's care
requirements; or
(c) circumstances existed which were provided for in the regulations as being a ground for withholding approval. [s. 44. (7)]

2. The licensee has failed to ensure that written notification was given to the following: 1. The applicant. 2. The Director. 3. The appropriate placement co-ordinator.

The Ministry of Health and Long-Term Care (MOHLTC) received a complaint related to the home refusing admission of resident #003.

During an interview with Case Manager (CM) #004, they stated that they were not the CM that was originally managing this application and that they were covering for the CM that the application was assigned to. CM #004 shared that they had received notification of the bed refusal through the portal used for reviewing applications however this did not include the rationale for the refusal or a justification for the decision and that no further documentation could be located.

Director of Care (DOC) #101 stated that they were the DOC at the time of the refusal. DOC #101 was unable to locate any documentation within the home related to refusal of admission of resident #003 but stated they were involved and familiar with the refusal. The DOC acknowledged that written notice was not provided to the Applicant or their Substitute Decision Maker, the MOHLTC or the placement co-ordinator and that the home should have done so.

The licensee has failed to ensure that written notification was given to the following: 1. The applicant. 2. The Director. 3. The appropriate placement co-ordinator. [s. 44. (10)]

Issued on this 23rd day of November, 2018

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

Original report signed by the inspector.