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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: November 15, 2023	
Inspection Number: 2023-1287-0004	
Inspection Type: Complaint Critical Incident	
Licensee: CVH (No. 4) 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: Pinecrest (Plantagenet), Plantagenet	
Lead Inspector Joelle Taillefer (211)	**Inspector Digital Signature** Joelle Taillefer Digitally signed by Joelle Taillefer Date: 2023.11.23 13:24:36 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 29, 2023 and October 3, 4, 5, 10, 11, 12, 13, 2023 (onsite) and October 16, 2023 (offsite).

The following intake(s) were inspected:
Critical Incident Report (CIS)
- Intake: #00097909 related to resident care and support services.

Complaint
- Intake: #00095871- related to allegation of abuse from resident to resident and resident care and support services.

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Construction, Renovation, Etc., of Homes

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 356 (3) 1.

The licensee has failed to receive the approval of the Director prior to commencing renovations in the home.

Rationale and Summary:
On September 29, 2023, Inspector #211 observed a tarp applied to a semi-private room's door which was sealed closed with tape. The Environmental Services Manager (ESM) showed Inspector #211 the water damage on one of the walls and a part of the ceiling area in this room.

The Executive Director stated that the renovation in the semi-private room started on October 10, 2023, and acknowledged that the renovations were commenced without first receiving the approval of the Director.

As such, there was a potential safety risk for residents to commence the renovation in the home without first receiving the approval of the Director.

Sources: Observation of a semi-private room. Interviews with the Environmental Services Manager and the Executive Director.
[211]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (11) (b)

The licensee has failed to ensure that a resident was reassessed because the care set out in the plan was not effective and that different approaches were considered in the revision of the plan of care.

Rationale and Summary:
A review of a resident's dietary referral on an identified date in 2023, showed that the resident had an incident of choking on a beverage.

Review of the resident's health care record indicated that a referral for a Registered Dietician (RD) assessment was completed on a date in 2023. Several days later, the RD documented on the dietary referral that the assessment was not performed as the resident was discharged.

The resident's care plan indicated to provide the resident with an identified diet texture and fluids consistency.

The resident's health care record did not indicate different approaches were considered related to the resident's diet texture nor the fluids consistency when the resident care set out in the resident's plan was not effective from the date of the dietary referral until the resident was discharged.

The Director of Care (DOC) stated that the referral for the RD was sent on an identified date in 2023.

As the resident's health care record did not identify different approaches that were considered in the revision of the plan of care related to the resident's diet texture and fluids consistency, the resident was potentially at risk for further choking issues.

Sources: A resident's health care records and interview with the DOC.
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WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4)

The licensee has failed to ensure that the staff and others involved in the different aspects of care of a resident collaborated with each other:
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Rationale and Summary:
A resident's current care plan did not indicate that the resident had responsive behaviours, but the

Assessment Instrument-Minimum Data Set (RAI-MDS) on a date in 2023, indicated that the resident had physical responsive behaviours. The Intervention/Task in the "Documentation Survey Report" for two identified dates in 2023, indicated that the resident had multiple responsive behaviours.

The DOC stated that the resident never demonstrated physical responsive behaviours towards other residents but was exhibiting another responsive behaviours toward other residents which was causing aggressive responsive behaviours from other residents. The DOC acknowledged that the resident's responsive behaviours in the RAI-MDS were inaccurate, and the resident's current plan of care and the intervention/task should indicate the resident's responsive behaviour type.

As the staff and others involved in different aspects of care of the resident did not collaborate with each other, the resident's assessment and the plan of care did not accurately indicate the resident's responsive behaviour type.

Sources: Resident's health care records, and interview with the DOC.
[211]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out for a resident was provided to the resident as specified in the plan.

Rationale and Summary:
On a date in 2023, a resident's health care records indicated that the resident presented with health care issues and an identified test was prescribed. A family member was informed of the treatment and if the resident's condition deteriorated, the resident would be sent to the hospital for evaluation.

On the next day, the resident's progress notes indicated that the identified test requisition was not completed as they were unable to locate the requisition.

During the inspection, the DOC stated that they were unable to locate the resident's test requisition and the result to indicate that the test was performed.

As the resident's test requisition and the result were not located, the care set out was potentially not

provided to the resident as specified in the plan.

Sources: A resident's progress notes and interview with the DOC.
[211]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that the licensee's written policy to promote zero tolerance of abuse of residents was complied with. As per, O. Reg 246/22 s. 2 (1) physical abuse means: c) the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary:
Specifically, the licensee's most current policy and procedures titled "Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct Program" #RC-02-01-01 2023, indicated:
-Promptly investigate resident-to-resident altercations, complaints and unexplained bruising or injuries to determine root cause and put in place measures to prevent recurrence.
-Staff must notify their supervisor (or during after-hours the Nurse on site). The Nurse would then call the Manager on-call or General Manager/designate immediately upon suspecting or becoming aware of abuse or neglect of a resident and/or unlawful conduct that resulted in harm or a risk of harm to a resident.
-Notify police authorities.
-The FLTCA provides that any person who has reasonable grounds to suspect that any of the following has occurred, or may occur, must immediately report the suspicion and the information upon which it is based to the Director of the Ministry of Long-Term Care (the "Ministry"): Abuse of a Resident by anyone or neglect of a Resident by the licensee or staff that resulted in harm or a risk of harm to the Resident.
-Anyone who suspects or witnesses abuse that causes or may cause harm to a resident is required to contact the Ministry of Long-Term Care (Director) through the Action Line.

On a date in 2023, a resident's progress notes indicated that an identified resident had exhibited physical responsive behaviors toward the resident, which resulted to an injury. On the following day, the progress notes indicated that the family member inquired about calling the police.

A Registered Nurse (RN) stated that they did not witness the physical responsive behaviors from the identified resident toward the other resident. The incident was reported during that shift by the resident

who stated being physically abuse by the identified resident. The RN stated that it was management who should contact the Director. A note of the incident was left for the DOC on the following day. The alleged incident of physical responsive behaviors from the identified resident toward the resident was not reported immediately to the manager on-call during that shift.

The DOC confirmed that the alleged physical abuse from the identified resident towards the other resident was not reported immediately to the Director and the police were not contacted.

Consequently, the alleged physical abuse from a resident toward the identified resident was not reported to the Director until one day later, as the licensee did not follow their policy and procedure titled "Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct Program", indicating that the nurse must notify the manager on call immediately upon suspecting or becoming aware of abuse of a resident. Furthermore, the licensee did not follow their policy indicating to contact the police authorities.

Sources: Residents' progress notes, policy "Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct Program" , and interviews with a Registered Nurse Staff and the DOC.
[211]

WRITTEN NOTIFICATION: Beds must be available

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 107 (2)

The licensee has failed to ensure that all beds that were allowed under the licensee were occupied or were available for occupation.

Rationale and Summary:
On September 29, 2023, Inspector #211 observed that a semi-private room was unoccupied by residents.

The Environment Services Manager (ESM) stated since there was water damage that affected one side of the wall and the ceiling in the semi-private room in February 2023, the room has been unoccupied by a resident since that time.

The Executive Director (ED) stated that water damage occurred on February 5, 2023. An inspector from the Ministry of Long-Term Care (MLTC) was informed by telephone that this room was unoccupied and

that resident admissions were put on hold until the water damage was repaired. The inspector suggested to put this room in abeyance until the area was repaired. As per the ED, the Southbridge supervisor was contacted, and they stated not to put the beds in abeyance. However, the project to repair the room took longer than expected and the room was still unoccupied at the time of the inspection.

As such, the licensee kept two beds in this room unoccupied and unavailable for occupation by residents since February 5, 2023.

Sources: Observation of a semi-private room, and interviews with Environmental Services Manager and the Executive Director.
[211]

WRITTEN NOTIFICATION: Altercations and other interactions between residents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between two residents, including implementing interventions.

Rationale and Summary:
A resident's progress notes indicated that another resident had exhibited physical responsive behaviours toward another resident on a date in 2023, and days later, which resulted in an injury to the resident. After the second incident, the Director of Care (DOC) documented that the resident expressed fear of other residents and would consider moving that resident to another calmer area.

A Personal Support Worker (PSW) stated that the resident had a specific responsive behaviour, which may trigger the other resident's physical responsive behaviours towards them. However, the PSW stated that they have never seen the identified resident exhibiting physical responsive behaviour toward the other resident, but the resident did have another type of responsive behaviour.

An RN stated there was an intervention put in place, but this intervention was not effective for the identified resident.

The DOC stated that the resident was told not to confront the identified resident, but to contact a staff

member by using the call bell or to inform a staff, but the resident may not remember to take those actions.

By not taking steps to minimize the risk of altercations and potential harmful interactions between both residents on a date in 2023, another harmful interaction occurred several days later.

Sources: Residents' health care records. Interviews with a PSW, RN and the DOC.
[211]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 1.

The licensee has failed to ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week: In a home with a licensed bed capacity of 69 beds or fewer, at least 17.5 hours per week.

Rationale and Summary:
Record review of the "Role and Responsibilities of an Infection Prevention and Control (IPAC) Lead" did not identify that the IPAC Lead worked at least 17.5 hours per week at the home.

Interview with the Executive Director stated that the IPAC Lead roles and responsibilities hours were divided between the Regional IPAC Lead and the RAI Coordinator for a total of 21 hours a week. The Regional IPAC Lead came to the home, once or twice during the week for a total of 16 hours per week. The Regional IPAC Lead would complete their role through video conference if unable to be present in the home twice a week.

The Regional IPAC Lead confirmed that they did not have a designated IPAC Lead working regularly in that position at the home for the required 17.5 hours per week.

As such there was a potential risk for residents' health and safety as the IPAC Lead did not work on site for the required 17.5 hours per week.

Sources: Policies review of "Roles and Responsibility of an IPAC Lead" dated July 14, 2023, and "Roles and Responsibility of the Regional IPAC Specialist" dated April 12, 2023. Interviews with the Executive

Director and the Regional IPAC Lead.
[211]

COMPLIANCE ORDER CO #001 Binding on Licensees

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
A)) Ensure that enhanced environmental cleaning and disinfection of frequently touched contact surfaces are performed more than once daily in outbreak areas, including in resident home areas, hallways, resident rooms, and resident bathrooms.
B) When the home is in outbreak, conduct audits to ensure compliance with cleaning and disinfecting high-touch surfaces and take immediate corrective actions if deviations occur from the developed housekeeping program for cleaning and disinfecting high-contact surfaces.
C) A written record must be kept of everything required under (A) and (B) deemed by the Ministry until the order is complied.

Grounds
The licensee has failed to comply with the Minister's Directive: Covid-19 response measures for long-term care homes effective August 30, 2022, to follow the Public Health Ontario as of July 16, 2021 "Coronavirus Disease 2019 (COVID-19), Key Element of Environmental Cleaning in Healthcare Settings" to clean and disinfect high touched contact surfaces more frequently when the home was in Covid-19 outbreak.

In accordance with the Public Health Ontario as of July 16, 2021, "Coronavirus Disease 2019 (COVID-19), Key Element of Environmental Cleaning in Healthcare Settings" indicated to clean and disinfect high touch or frequently touched surfaces at least once per day and more frequently in outbreak areas. Examples of these surfaces include doorknobs, call bells, bedrails, light switches, toilet handles, handrails, and keypads.

Rationale and Summary:
The home was declared in Covid-19 outbreak on September 28, 2023.

On October 3, 2023, a Housekeeping Aide reported that the enhanced environmental cleaning and disinfection of frequently touched contact surfaces had been performed once daily, which included the resident's bedrooms, bathrooms, hallways, and other areas when they were not in Covid-19 outbreak.

The high touch surfaces in the North Wing were cleaned and disinfected once daily during the day shift. The high touch surfaces in the East Wing were cleaned and disinfected once daily during the evening shift. However, during the Covid-19 outbreak, the high touch contact surfaces in resident's bedrooms and bathrooms were cleaned and disinfected once daily while the other areas such as the corridor railings, staff room, and the front entrance were cleaned and disinfected more than once daily.

On October 3, 2023, the Environmental Services Manager (ESM) stated that the frequently touched contact surfaces were cleaned and disinfected once per day during Covid-19 outbreaks in the home and occasionally in some areas, the high touch surfaces were cleaned and disinfected more than once daily. The ESM stated that they should have additional housekeeping staff hours to ensure that the high touch surfaces are cleaned and disinfected more frequently when they are in outbreak.

As such, the residents were at risk of cross-contamination when the home had not cleaned and disinfected the high touch surfaces in the Covid-19 outbreak areas more than once daily.

Sources: The Minister's Directive: Covid-19 response measure for long-term care homes, effective August 30, 2022, the Public Health Ontario as of July 16, 2021, titled "Coronavirus Disease 2019 (COVID-19), Key Elements of Environmental Cleaning in Healthcare Settings" and interviews with a Housekeeping Aide, the Environmental Services Manager, and the Executive Director.
[211]

This order must be complied with by December 27, 2023

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:

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.