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

London District
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London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: April 4, 2024

Inspection Number: 2024-1009-0002

Inspection Type:
Critical Incident

Licensee: CVH (No. 8) 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: Queensway Long Term Care Home, Hensall

Lead Inspector	**Inspector Digital Signature**
Tatiana McNeill (733564)	Tatiana McNeill Digitally signed by Tatiana McNeill Date: 2024.04.04 15:28:01 -04'00'

Additional Inspector(s)
Joy Kacsandi #000821 and Mark Smith #000815 were also present during this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 26, and 27, 2024

The following intake(s) were inspected:

- Intake: #00102510 – CIS # 0933-000013-23 related to Falls Prevention and Management.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

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.

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

Rationale and Summary

The resident's care plan noted that they were to have an assistive aid for their safety.

The resident was observed in a group activity, without their assistive aid in place.

A Registered Practical Nurse (RPN) confirmed that the resident did not have their assistive aid in place at that time.

On another day, the resident was observed at mealtime without their assistive aid in place. A Registered Nurse (RN) noted the assistive aid was in place but not activated.

The resident's assistive aid not being provided and utilized as per their care plan potentially put them at risk for falls.

Sources: Review of the resident's clinical records, observations in the home, and

interview with RPN and RN. [733564]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (c)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

The licensee has failed to ensure that a resident's care plan was updated when their care set out in the plan has not been effective.

Rationale and Summary
Record review of a resident's care plan noted that they were required to have a assistive aid as well as another assistive device for their safety.

A Registered Nurse (RN) stated that the resident was non-compliant with the assistive device. The RN stated the resident was to have an assistive aid for safety.

Acting Director of Care (DOC) acknowledged that the resident's care plan should have been updated to reflect their current falls prevention interventions.

There was risk to the resident when their care plan did not reflect their current falls prevention interventions.

Sources: Record review of the resident's care plan, interviews with RN and Acting DOC. [733564]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

19. Every resident has the right to,

iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure that residents have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

Rationale and Summary

Observations completed in the home noted the Electronic Medication Administration Record (eMAR) screen on a medication cart was left open, revealing the medical chart of a resident. There were no staff members protecting the resident Personal Health Information (PHI) present near the medication cart.

A few minutes later, a Registered Practical Nurse (RPN) returned to their medication cart and continued with the medication administration process. The RPN was observed the second time going into a resident's room and leaving the medication cart with the screen unlocked, revealing the medical chart of another resident.

On return to the medication cart, the RPN confirmed that they left the computer screen unlocked while administering medication to two residents down the hall.

Review of the home's Medication Management policy # RC-16-01-07, last reviewed March 2023 noted staff were required to ensure that the eMAR screens on the medication carts were locked prior to leaving the cart, to ensure residents' privacy.

Acting Director of Care (DOC) stated that the RPN should have locked the computer screen while leaving the cart unattended, to protect residents' PHI.

Failure to protect the resident's PHI on the e-MAR put them at risk of having their PHI jeopardized.

Sources: observations in the home, review of home's Medication Management policy # RC-16-01-07, last reviewed March 2023, interview with RPN and DOC. [733564]

WRITTEN NOTIFICATION: Late Reporting

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (4) (b)

Reports re critical incidents

s. 115 (4) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,

(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (5). O. Reg. 246/22, s. 115 (4).

The licensee has failed to ensure that the Director was informed of a significant change in health to a resident, within three business days after the occurrence of the incident, after they sustained an unwitnessed fall resulting in a change in health condition.

A Critical Incident System (CIS) Report was submitted to the Director related to an unwitnessed fall that a resident had sustained, resulting in a change in their health condition.

The resident returned from medical treatment, and a review of their clinical records indicated that they had a significant change in their condition. A Registered Nurse (RN) stated that the home was made aware of the resident's change in health condition.
Acting Director of Care (DOC) acknowledged that the Director was not informed of the incident within three business days after the occurrence of the incident, after the resident sustained an unwitnessed fall resulting in a change in their health condition.

There was no risk to the resident when the home did not inform the Director within three business days after the occurrence of the incident, after the resident sustained an unwitnessed fall resulting in a change in health condition.

Sources: Review of clinical records for the resident and interviews with RN, and Acting DOC. [733564]