Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 27, 2020	2020_768693_0021	015733-20	Complaint

Licensee/Titulaire de permis

CVH (No. 9) 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 CAMBRIDGE ON N3H 5L8

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

Southbridge Lakehead
135 South Vickers Street THUNDER BAY ON P7E 1J2

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

MELISSA HAMILTON (693)

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): October 5 and 6, 2020.

The following intakes was inspected upon during this Complaint (CO) inspection:
-an intake, regarding care concerns for a resident.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Medical Director (MD), Director of Care (DOC), Associate Director of Care (ADOC), a Registered Nurse (RN), and a Registered Practical Nurse (RPN).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
2 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate 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 2007, c. 8, s. 6 (4).
(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. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. 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 to ensure their assessments of a resident were integrated, consistent, and complimented each other.

A complaint was submitted to the Director, by a resident’s family member, related to care concerns.

A review of the progress notes indicated that the resident had sustained an unwitnessed fall and was sent to the hospital where they passed away on a later date. In addition, it was indicated that the resident had experienced a change in status, that the MD was notified of this, and the resident was sent to hospital; after the MD had spoken with the resident's family member.

During an interview with an RPN, they indicated they thought that they had informed the MD of the resident's vomiting episode and unresponsiveness, soon after the time it had occurred, and if they had this would be documented in the progress notes. The RPN indicated they had assessed the resident as being at their baseline and did not suspect that a specific health abnormality had occurred.

During an interview with an RN, they indicated that they had thought from their assessment of the resident, they had experienced a specific health abnormality, and communicated this to the MD.

During an interview with the MD, they indicated that the progress notes read that the resident became unresponsive and vomited, and that they documented they were informed of this at an identified time. The MD indicated that the nursing staff never

communicated to them that they had thought the resident experienced a specific health abnormality, and that through their assessment the MD suspected a pain response or fracture in the resident.

During an interview with the DOC they indicated that it was documented that the MD was not informed of the resident's change in status, until two hours after it had occurred, however; they thought (after reviewing the incident) that this was a typo and that the MD had been informed 10 minutes after the resident’s health status changed. The DOC indicated that there were gaps in the documentation of care for the resident.

Sources: Interviews with the DOC and other staff, progress notes for the resident, LTCH’s investigation file, the resident's medical record and assessments. [s. 6. (4) (a)]

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 the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home.

A complaint was submitted to the Director, by a resident's family member, related to care concerns.

A review of the progress notes indicated that the resident had sustained an unwitnessed fall.

Inspector #693 reviewed the resident’s medical record and identified a Clinical Monitoring Record. The record indicated that pain assessments, vital signs, and neurovital signs, were to be assessed every hour for four hours. Upon review of the Clinical Monitoring Record and resident’s electronic medical record, the Inspector identified that pain assessments, vital signs, and neuroviral signs were not documented every hour for four hours.

During an interview with the DOC, they reviewed the Clinical Monitoring Record, and indicated that the staff may have completed pain assessments, and assessed the resident’s vital signs and neurovital signs hourly, after their fall, but they were not documented; so there was no way to confirm that they were done in accordance with the home’s Falls Prevention program.

Sources: Interviews with the DOC and other staff; the resident's progress notes and medical record; “Fall Prevention and Management Program, RC-15-0101” (dated December, 2019); and a post falls assessment. [s. 48. (1) 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 the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury, to be implemented voluntarily.

Issued on this 29th day of October, 2020

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

Original report signed by the inspector.