Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 17, 2019	2019_703625_0015	005667-19, 010427-19, 012562-19	Critical Incident System

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 Pinewood
2625 Walsh Street East THUNDER BAY ON P7E 2E5

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

KATHERINE BARCA (625)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 22 to 26, July 29 to 31, 2019; August 1, 7, 8, 12 and 14, 2019.

The following Critical Incident System (CIS) intakes were inspected during this CIS inspection:
- logs #005667-19, #010427-19 and #012562-19, related to CIS reports #2962-000004-19, 2962-000009-19 and 2962-000013-19, respectively, submitted for three falls sustained by three residents, for which the residents were taken to hospital and resulted in significant changes in the residents' health conditions.

The following non-compliance identified in this CIS inspection has been issued in Follow-up inspection report #2019_703625_0016, which was conducted concurrently:
- a Written Notification (WN) and Compliance Order (CO) related to the Long-Term Care Homes Act (LTCHA), 2007, c.8, s. 6 (1) (c);
- a WN and CO related to Ontario Regulation (O. Reg.) 79/10, s. 8 (1) (b); and
- a WN and Voluntary Plan of Correction (VPC) related to O. Reg. 79/10, s. 131 (2).

During the course of the inspection, the inspector(s) spoke with residents, residents' family members, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), a Physiotherapy Assistant (PTA), Physiotherapists (PTs), an Associate Director of Care (ADOC), the Director of Nursing (DOC) and the Executive Director (ED).

The Inspector also conducted daily tours of the home, observed the care and services provided to residents, and observed interactions between and among staff and residents. The Inspector reviewed records including, but not limited to, residents' health care records; home's programs, policies, protocols and guides related to falls prevention and management, skin and wound care and/or pain management; staff schedules; CIS reports; and an internal incident report.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Skin and Wound Care

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	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).

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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of resident #005 collaborated with each other in the development and implementation of the resident's plan of care, so that the different aspects of care were integrated and were consistent with and complemented each other, with respect to resident #005's mobility status.

A CIS report was submitted for a fall experienced by resident #005, in the summer of 2019, where the resident was taken to hospital and which resulted in a significant change

in the resident's health condition. The CIS report identified post-fall interventions including that the resident may use a mobility aid in a particular situation. The report also identified that, when mobilizing in particular situations, the resident needed specific assistance, as well as contrarily identified that the resident was not to use their mobility aid at that time due to an injury. The report further indicated that, to address their risk for falls/risk for fractures, the resident would use a second mobility aid for mobility for safety.

Inspector #625 observed resident #005 using a mobility aid in their room and on their home area on multiple dates in the summer of 2019. On one date in the summer of 2019, the Inspector also observed the resident use the mobility aid in a different manner than observed on other occasions, with no staff present. On another date in the summer of 2019, the Inspector observed the resident mobilize using a different mobility aid, on a floor in the home on which they did not reside.

Inspector #625 reviewed the resident's current care plan which identified:
- under the focus related to toileting, the resident would use one mobility aid in a particular situation with the assistance of staff;
- under the focus related to walking in room/corridor/on and off unit, the resident would use a second mobility aid in particular situations for their safety, required assistance while mobilizing in a particular manner, and was not able to use the mobility aid referred to in the toileting focus at that time; and
- under the focus risk for falls/risk for fractures, the resident was not able to use the mobility aid referred to in the toileting focus at that time and would use a second mobility aid for mobility for safety.

A physiotherapy assessment completed by PT #108 effective on a date in the summer of 2019, identified that resident #005 required the use of the second mobility aid for functional mobility and that physiotherapy staff would provide a particular mobility program until further assessment.

A progress note entered by RPN #104, two days after the physiotherapy assessment in the summer of 2019, identified that mobility in the resident's room, to and from their bathroom, could be done with the first mobility aid and the assistance of staff, while mobility outside of their room (to and from the dining room, activities, etc.) would be completed with the second mobility aid for safety.

A progress note entered by PTA#107, dated the following month, identified that resident #005's first mobility aid exhibited an unsafe characteristic when being used and they

showed the mobility aid to the vendor who would fix it.

During an interview with PSW #105, they stated that they had not been provided any direction on resident #005's use of the first mobility aid after a PT assessment that occurred in the summer of 2019. The PSW stated they had asked resident #005 if they had wanted to use the first mobility aid on that date and the resident stated they preferred to wait. During a subsequent interview with the PSW, they stated that they thought resident #005 was ready to use the first mobility aid, and that they had mobilized with the resident a short distance in the hallway using their first mobility aid.

During an interview with RPN #106, they stated that resident #005 should have staff assistance to mobilize with the first mobility aid in their room. The RPN reviewed resident #005's current care plan and stated it needed to be updated to have consistency through the care plan with respect to the resident's use of the first mobility aid.

During interviews with RPN # 104, they stated that staff had used the resident's first mobility aid with the resident for short distances after their fall in the summer of 2019. The RPN identified that, after the resident had a subsequent fall using the first mobility aid, it was evident that they could not safely use the mobility aid with an injury, so it was removed from their room so they could not try to use it themselves. The RPN stated that the PT had entered a note for the resident not to use the first mobility aid and should have collaborated with the nursing staff to update the rest of the resident's care plan when they entered the note. The RPN stated they had spoken to the DOC about the lack of communication between the nursing staff and the PT about changes made.

During an interview with PTA #107, they stated that the physiotherapy department mobilized with resident #005 using a physiotherapy mobility aid which was of the same general type as the resident's first mobility aid, but which had a different characteristic relating to how it operated, as resident #005's own mobility aid exhibited a particular characteristic and was not safe for them to use. The PTA stated that resident #005 should not be using the first mobility aid to get around their room, as the PT had assessed that the resident should not be using the first mobility aid.

During an interview with PT #108, on a date in the summer of 2019, they stated that resident #005's own mobility aid exhibited a particular characteristic, which they had informed the vendor of as it was not safe and needed to be fixed. The PT stated the resident fell frequently due to a symptom they experienced, and was at risk of falling, which was why the resident was assessed to use the second mobility aid, not the first

mobility aid. The PT stated that, resident #005's specific medical device had been removed the previous week, that the resident needed to start slowly with getting back to using the first mobility aid, and that physiotherapy would work on increasing the resident's ability now that the resident no longer used the medical device. The PT stated that, when it was safe, they would let nursing staff know so they could assist the resident use the mobility aid, until then they were to continue with the last assessed physiotherapy assessment of mobility that listed the resident was to use the second mobility aid.

During an interview with ADOC #102, they stated that the thought from [nursing] staff, was that resident #005 was safe to use the first mobility aid for some things and not for others. The ADOC stated that the interventions that detailed resident #005 could use the first mobility aid in a particular circumstance were included in the care plan on a date in the summer of 2019, after the resident fell, as the intention was that the staff didn't want the resident mobilizing around in their room with the mobility aid by themself, but it was okay for the resident to use the mobility aid with staff assistance in a particular circumstance. The ADOC stated that collaboration between nursing staff and physiotherapy staff on the development and implementation of the plan of care was not cohesive.

During an interview with the DOC, they acknowledged that staff involved in different aspects of resident #005's care had not collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other, with respect to resident #005's mobility aid use. [s. 6. (4) (b)]

2. The licensee has failed to ensure that the care set out in resident #002's plan of care, related to their use of bed rails, was provided to the resident as specified in the plan.

A CIS report was submitted for a fall experienced by resident #002, in the winter of 2019, where the resident was taken to hospital and which resulted in a significant change in the resident's health condition.

During observations of resident #002's room by Inspector #625, on dates in the summer of 2019, the Inspector noted that one bed rail was lowered and not engaged, while another bed rail was engaged.

During review of resident #002's care plans in place pre-fall, post-fall and currently, each

identified that the resident used bed rails on both sides of the bed for turning and repositioning, as per their bed rail risk assessment.

A review of resident #002's most recent Bedrail Risk Assessment generated progress note, completed by RPN #109 and dated the spring of 2019, identified that the resident had been individually assessed and used two bed rails as personal assistance services devices (PASDs).

During an interview with resident #002 in the summer of 2019, they stated that they had used one bed rail earlier that day to grab and help the resident turn when staff had provided the resident with personal care. During a subsequent interview with the resident two days later, they stated that they used both bed rails to move around in bed, that one bed rail was not raised, but staff would tell the resident to grab on to it when it was lowered because the resident needed to use it when they were provided with personal care.

During an interview with resident #002's family member #110, they stated they had never seen one of the resident's bed rails raised since the resident moved to that home area.

During an interview with PSW #111, they stated that resident #002 only had one bed rail on one side of their bed because the bed was against the wall so the other bed rail was down. The PSW elaborated that the resident used the bed rails for turning and grabbed onto the top of the lowered bed rail during care, even when it was lowered, due to the resident's concerns about falling. The PSW confirmed the current care plan identified the resident was to use two bed rails.

During an interview with RPN #112, they stated that resident #002 had transferred to that home area in the spring of 2019. The RPN stated the resident's care plan identified they used two bed rails, but they were not sure if they had ever seen the second bed rail raised.

During an interview with RPN #109, they stated that, if resident #002's care plan identified both bed rails were used, then both should be engaged/locked. The RPN stated they thought that one bed rail may have been lowered, when the resident moved to the home area, because the bed had been placed against the wall. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in resident #004's plan of care, with respect to completion of a Dementia Observation System (DOS) tool, was provided

to the resident as specified in the plan.

A CIS report was submitted for a fall experienced by resident #004, in the spring of 2019, where the resident was taken to hospital and which resulted in a significant change in the resident's health condition. The report identified the resident sustained injuries, the resident returned to the home on another date in the spring of 2019, and the DOC spoke with the resident's family member about pain the resident was experiencing.

Inspector #625 reviewed resident #004's health care record including a Digital Prescriber's Orders entry dated the spring of 2019, which ordered staff to complete a DOS tool for multiple days.

A review of the DOS tool completed for resident #004 over multiple days in the spring of 2019, identified the following blank entries:
- on one date, 2 out of 44, or five percent, of the entries were blank;
- on another date, 16 out of 48, or 33 per cent, of the entries were blank;
- on another date, 32 out of 48, or 66 per cent, of the entries were blank;
- on another date, 15 out of 48, or 31 per cent, of the entries were blank;
- on another date, 15 out of 48, or 31 per cent, of the entries were blank;
- on another date, eight out of 48, or 17 per cent, of the entries were blank; and
- on another date, 15 out of 48, or 31 per cent, of the entries were blank.

In total, 31 per cent of the prescriber's ordered DOS entries were blank.

During an interview with the DOC, they acknowledged that care had not been provided to resident #004 as set out in their plan of care with respect to completion of the DOS. [s. 6. (7)]

4. The licensee has failed to ensure that the care set out in resident #005's plan of care, with respect to their use of specific falls related equipment, was provided to the resident as specified in the plan.

A CIS report was submitted for a fall experienced by resident #005, in the summer of 2019, where the resident was taken to hospital and which resulted in a significant change in the resident's health condition. The CIS report identified that interventions put in place post-fall for resident #005 indicated that "Interdisciplinary Post Fall Huddle held, determined that [specific falls related equipment] not appropriate for resident due to risk for tripping or causing additional falls".

On a date in the summer of 2019, at approximately 1230 hours, Inspector #625 observed resident #005 laying in bed with the specific falls related equipment in use. During a second observation at approximately 1500 hours, the Inspector observed resident #005 transfer in an unsafe manner with the specific falls related equipment in use, from their bed to a mobility aid.

A review of resident #005's care plan in place on the date of the Inspector's observations, identified an intervention for "[specific falls related equipment] in place at HS and removed during the day".

During an interview with PSW #113, they stated that they had provided care to resident #005 during the day shift of the Inspector's observations. The PSW stated they used the resident's specific falls related equipment when the resident was in bed, including during the day, and had done so that day, when the resident was in bed. When the Inspector asked about the resident's current care plan which identified the specific falls related equipment was to be used at night, the PSW stated they believed the resident should have the equipment in use whenever they were in bed.

On a date in summer of 2019, during an interview with RPN #104 (who had been present during the resident's transfer observed by the Inspector), they acknowledged that resident #005's specific falls related equipment had been in use during the afternoon and said that staff may use the specific falls related equipment when the resident was in bed. [s. 6. (7)]

5. The licensee has failed to ensure that the provision of care set out in resident #002's plan of care was documented, specifically related to the administration of analgesic medication to the resident.

A CIS report was submitted for a fall experienced by resident #002, in the winter of 2019, where the resident was taken to hospital and which resulted in a significant change in the resident's health condition. The report identified the resident had sustained an injury.

Inspector #625 reviewed resident #002's health care record including:
- a progress note dated the spring of 2019, that identified "A 72 hour pain assessment to be completed on the day and evenings shifts has been started on this resident due to a new pain medication being ordered";
- a pain assessment dated the same date, that was completed for new pain related medication and identified "This resident is now getting scheduled [analgesic medication]

..."; and
- pain assessments dated the following date, and dated two days later, which identified the reasons for the pain assessments as "New Pain related Medication".

A review resident #002's health care record with a focus on analgesic medications identified a Digital Prescriber's Orders entry, dated the date before the progress note, for scheduled analgesic medication.

Inspector #625 reviewed resident #002's electronic Medication Administration Record (eMAR) for a particular month in 2019 and noted that the analgesic medication was listed on the eMAR for daily administration starting on the date of the progress note. The areas where staff were required to document the analgesic administration were blank on the dates corresponding to the reviewed progress note and pain assessments, and did not reflect if the medication had been administered, held, refused, not available, etc.

During an interview with the DOC, they indicated that staff had not documented the administration of the analgesic on specific dates in the spring of 2019. [s. 6. (9) 1.]

6. The licensee has failed to ensure that resident #004 was reassessed and their plan of care reviewed and revised when the resident's care needs changed, with respect to bed mobility.

A CIS report was submitted for a fall experienced by resident #004, on a date in the spring of 2019, where the resident was taken to hospital and which resulted in a significant change in the resident's health condition. The report identified the resident had returned to the home on another date in the spring of 2019; upon return from hospital, the resident required assistance of staff with bed mobility; and the resident's care plan would continue to be revised as the resident recuperated.

During multiple observations of resident #004's bed mobility throughout the inspection, Inspector #625 observed the resident independently mobilize in bed.

Resident #004's current care plan identified the resident required specific assistance of staff with bed mobility due to physical limitations from a recent injury.

During an interview with PSW #114, they demonstrated with resident #004 that the resident was able to mobilize in bed with supervision provided by the PSW.

During an interview with PT #115, they stated that resident #004 was a good example of improvement after a specific type of injury and their care plan was not accurate when it identified the resident required a specific type of staff assistance with bed mobility.

During an interview with the DOC, they indicated that, if resident #004 no longer required specific staff assistance for bed mobility, but was able to independently mobilize in bed, the resident's care plan had not been reviewed and revised when their care needs changed with respect to bed mobility. [s. 6. (10) (b)]

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 that ensures that:
- staff and others involved in the different aspects of care of the resident collaborate with each other 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;
- the care set out in the plan of care is provided to the resident as specified in the plan; and
- the provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

(a) On a date in the summer of 2019, at a particular time, Inspector #625 observed the door to the Wellness Centre room on a specific home area to be opened and unsupervised. The door had a sign affixed to it that read "KEEP DOOR LOCKED AT ALL TIMES".

(b) On another date in the summer of 2019, at a particular time, Inspector #625 observed the door to a specific Equipment room opened and unsupervised.

During an interview with RN #116, they stated that they had previously been monitoring the equipment room door, but that the door to the room they were in closed further so they could no longer see the equipment room door.

During an interview with the ADOC, they stated that the door was supposed to be kept closed when not in use or supervised.

(c) On the same date, at another particular time, Inspector #625 observed one home area's shower room door held open with a door stop. Staff were not present or supervising the door.

During an interview with PSW #117, they stated that the door to the shower room should have been closed.

(d) On the same date, at another particular time, Inspector #625 observed the door to another specific Equipment room opened and unsupervised. The door had a sign affixed to it that instructed staff to keep the door locked at all times

During an interview with RPN student #118, they stated that the door should not be left opened.

During an interview with the DOC, they stated the doors to wellness rooms, equipment rooms and shower rooms should be closed and locked when staff were not present or supervising the area. [s. 9. (1) 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 that ensures that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and that those doors are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when required to inform the Director of an incident under subsection (1), (3) or (3.1), within 10 days of becoming aware of the incident, or sooner if required by the Director, the licensee made a report in writing to the Director that set out a description of the incident, including the events leading up to the incident, specifically the events leading up to resident #005's fall in the summer of 2019.

A CIS report was submitted for a fall experienced by resident #005, in the summer of 2019, where the resident was taken to hospital and which resulted in a significant change in the resident's health condition. The report identified the resident had returned to the home at a particular time [on the following date]. The description of the incident provided in the report, including events leading up to the critical incident, included that a PSW overheard the resident fall, and the subsequent positioning, actions and injury of the resident. The report did not identify the events leading up to the incident, or the cause of the fall, but did identify the resident's cognition was borderline intact.

During an interview with resident #005 and their family member #119, the family member stated the resident fell when reaching for an item. The resident then elaborated that they had been in contact with an entity regarding financial information and had been required to provide them with information they had been reaching for. The resident said their mobility aid had not been close by when they fell, they had been standing, leaned over to reach for the information and then fell.

During an interview with the DOC about the events leading up to resident #005's fall, they reviewed an internal incident report for the known circumstances of the fall and stated that the internal incident report had identified the resident was performing a specific activity and fell over, using parts of their body to break the fall. The DOC stated that the CIS report to the Director identified how staff became aware of the fall, but did not identify how the fall had occurred. [s. 107. (4) 1.]

Issued on this 25th day of October, 2019

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

Original report signed by the inspector.