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
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Original Public Report

Report Issue Date: January 12, 2024

Inspection Number: 2023-1184-0006

Inspection Type:
Complaint
Critical Incident

Licensee: Carveth Nursing Home Limited

Long Term Care Home and City: Carveth Care Centre, Gananoque

Lead Inspector	**Inspector Digital Signature**
Heath Heffernan (622)	Heath Heffernan Digitally signed by Heath Heffernan Date: 2024.01.16 09:39:11 -05'00'

Additional Inspector(s)
Kayla Debois (740792)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 16, 17, 20 - 24, 27 - 30, 2023 and December 5 - 8, 11, 12, 2023.

The following intake(s) were inspected:
- Intake: #00095815 and #00096972 – Complaint regarding resident care and support services.
- Intake: #00096800 – Complaint regarding responsive behaviours and resident care and support services.
- Intake: #00097522, 00098442, and 00100304 - Complaint regarding skin and wound care.
- Intake: #00099208 and #00099268/CIS #2683-000012-23 - Complaint regarding continence care, food, nutrition and hydration and medication

management.
- Intake: #00100480 - Complaint regarding resident care and support services and sufficient staffing.

- Intake: #00097176/CIS #2683-000006-23 and #00097216/CIS #2683-000007-23 – Critical incident regarding alleged resident-to-resident sexual abuse.
- Intake: #00098712/CIS #2683-000009-23 – Critical incident regarding alleged staff to resident verbal abuse.
- Intake: #00098722/CIS #2683-000010-23 – Critical incident regarding alleged staff to resident physical abuse.
- Intake: #00100264/CIS #2683-000014-23 – Critical incident regarding alleged staff to resident physical and verbal abuse.

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

Skin and Wound Prevention and Management
Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. 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.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to the resident, immediately reported the suspicion and the information upon which it is based to the Director.

Rationale and Summary
In a review of a resident's progress notes on PointClickCare (PCC), on a day in November 2023, the resident was found in a co-resident's room allegedly hitting the co-resident. The co-resident was not injured and the resident was redirected out of the room. This incident of alleged resident to resident physical abuse was reported to the Director twelve days after the incident occurred.

In an interview with a Registered Nurse (RN), they stated that they were the charge nurse that day and they did not report this incident to the management because they were unaware of the MLTC reporting requirements. In an interview with the Director of Care (DOC), they acknowledged that the above incident was not

reported to the Director immediately.

Failing to immediately notify the Director of alleged resident abuse places residents at risk of additional harm.

Sources: Resident's progress notes in PCC, interview with an RN and the DOC. [740792]

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 3.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
3. Resident monitoring and internal reporting protocols.

The licensee failed to comply with their written policy related to the behavioural protocols for a resident.

In accordance with O. Reg 246/22, s. 11 (1) b, the licensee is required to ensure that their written policy related to behavioural assessment and care management of a resident is complied with.

Specifically, staff did not comply with the Behavioural Assessment and Care Management policy (revised June 13, 2023): initiate the assessment tools related to the behaviour present. For physically or verbally abusive behaviours, complete a Dementia Observation Scale (DOS).

Rationale and Summary

A resident was admitted to the home on a day in July 2023 with a history of responsive behaviours. According to the progress notes on PointClickCare (PCC), on a day in October 2023, the resident was going into co-resident's rooms and yelling at them. When trying to redirect, the resident became verbally abusive. On a day in November 2023, the resident was agitated and aggressive towards staff and residents, going into co-resident's rooms and yelling at them. On another day in November 2023, the resident was pacing the hallways and being verbally aggressive towards staff and residents. The resident was then found in a co-resident's room, allegedly hitting them.

Inspector was unable to locate a BSO-DOS that was initiated/completed for the resident.

In an interview with the Clinical Care Co-Ordinator, they confirmed that there were no BSO-DOS sheets filled out as per the home's policy for the resident when they were having these behaviours.

By not ensuring the written policy related to behavioural assessment and care management was complied with, management of the resident's responsive behaviours may not have been identified in a timely manner.

Sources: Resident's electronic and paper copy health record, Behavioural Assessment and Care Management policy (revised June 13, 2023), interview with the Clinical Care Co-Ordinator.
[740792]

WRITTEN NOTIFICATION: Involvement of resident, etc.

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

Non-compliance with: FLTCA, 2021, s. 6 (5)

Plan of care

Involvement of resident, etc.

s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

1) The licensee has failed to ensure that a resident's substitute decision maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

On a day in June 2023, a resident's progress notes on PointClickCare (PCC) indicate they sustained a specified injury from the sling during care. Within the progress notes, there was no documentation indicating that the resident's SDM was made aware of this.

In an interview with a Registered Practical Nurse (RPN), they confirmed that the resident's SDM was not notified of the skin alteration that occurred on a day in June 2023.

In an interview with the DOC, they confirmed that SDM's should be notified of skin alterations, including skin tears, and acknowledged there are times where this doesn't happen.

Not notifying the SDM when there has been a change in the resident's condition does not give the SDM an opportunity to participate fully in the development and

implementation of the resident's plan of care.

Sources: Resident's progress notes in PCC, interview with the DOC and an RPN. [740792]

2) The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
Review of the progress notes and Treatment Administration Record (TAR) indicated on a date in August 2023, a resident had skin breakdown. There was no documentation to support that the resident's SDM had been notified of the resident's change in condition.

In an interview with Inspector #622, the Registered Practical Nurse (RPN) stated that when a resident has a change in condition such as skin breakdown, the SDM is to be notified and documented in the progress notes.

In an interview with Inspector #622, the SDM stated that they had not been notified of the resident's skin breakdown.

By not notifying the SDM when there has been a change in the resident's condition, does not give the SDM an opportunity to participate fully in the development and implementation of the resident's plan of care.

Sources: Review of the resident's progress notes and TAR and interview with the SDM, RPN and other staff.

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WRITTEN NOTIFICATION: Documentation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
Documentation
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.

1) The licensee has failed to ensure that the documentation for the meal intake for a resident was completed.

Rationale and Summary
The licensee has failed to ensure that the documentation for the meal intake for a resident was completed.

Rationale and Summary:
Review of the meal intake flow sheets on PointClickCare (PCC) for a time period of 26 days in November 2023, indicated that there was no documentation completed for the resident's lunch intake on three separate dates. There was no documentation completed for the resident's dinner intake on four separate dates.

During an interview with the DOC, they acknowledged that documentation of resident's meal intake is not always completed.

Failing to ensure resident's intake during meals is documented can increase the risk of uncertainty of the resident's intake level.

Sources: Meal intake documentation for a resident, interview with the DOC.
[740792]

2) The licensee has failed to ensure that the documentation for the Behavioural Supports Ontario-Dementia Observation System (BSO-DOS) for a resident was completed.

Rationale and Summary
Review of the BSO-DOS sheets from a five day time period in September 2023 for a resident, indicated that documentation was not completed on two complete days, and on an identified date from 1130 to 1330 hours, 1400 to 0700 hours, a second identified date from 0700 to 1500 hours, and a third identified date from 0700 to 1500 hours, 2330 to 0700 hours.

During an interview with the Clinical Care Co-Ordinator, they acknowledged that there were gaps in the resident's DOS documentation and the expectation is that it's filled out completely.

Failing to ensure resident's behaviours are documented can increase the risk of uncertainty whether the behaviour was present or not.

Sources: BSO-DOS documentation for a resident, interview with the Clinical Care Co-Ordinator.
[740792]

3) The licensee has failed to ensure that the documentation for the fifteen minute safety checks for a resident was completed.

Rationale and Summary
On a day in September 2023, a resident was witnessed in a co-resident's room, allegedly sexually abusing them. The resident was re-directed out of the room. On another day in September 2023, the resident was witnessed allegedly sexually abusing another resident. On the same day in September 2023, the resident was sent to the hospital for assessment. The resident returned from the hospital and was placed on fifteen minute safety checks six days later.

Review of the fifteen minute check sheets for a time period of nine days in September 2023, indicated that documentation was not completed for the resident on an identified date from 0700 to 2300 hours, a second identified date from 0700 to 1445 hours, a third identified date from 1530 to 0645 hours, a fourth identified date from 1515 to 2245 hours, and a fifth identified date from 0700 to 1445 hours and 0600 to 0645 hours.

During an interview with the Clinical Care Co-Ordinator, they stated that it is the expectation that fifteen minute checks are documented completely.

Failing to ensure increased checks are documented can increase the risk of uncertainty whether the resident was checked or not.

Sources: Clinical electronic records for a resident, Q15 minute checks for a resident, interview with the Clinical Care Co-Ordinator.
[740792]

4) The licensee has failed to ensure that the provision of the care set out in a resident's activities of daily living plan of care was documented.

Rationale and Summary
Review of a resident's task documentation for the provision of care; dressing, grooming and oral hygiene, during a thirty eight day period, indicated that there were nine dates with omissions in documentation.

In separate interviews with Inspector #622, two Personal Support Workers (PSWs) stated that the resident would have received care for dressing, grooming and oral hygiene however, staff had missed documenting.

Failing to ensure that a resident's personal care is documented increases the uncertainty that the resident's care is being completed.

Sources: Review of the resident's health records and interview with a PSW and other staff.
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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)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the licensee's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Specifically, staff did not comply with the licensee's policy: #024 - Reporting of Abuse or Neglect, (reviewed: June 13, 2023) which stated that if an employee of Carveth Care Centre, witnesses any action related to abuse and or neglect in the workplace, they must immediately report the incident to a member of the management team including the registered nurse on duty.

Rationale and Summary
A Critical Incident System report (CIS) #2683-000014-23 was submitted on a date in October 2023, related to an incident of alleged abuse between a staff member and a resident.

Review of an email sent by a staff member to the Director of Care (DOC) and the Assistant Director of Care (ADOC) on a date in October 2023, indicated that the alleged incident of abuse between the staff member and resident took place two days earlier.

During an interview with Inspector #622 on December 7, 2023, the staff member stated that they did not immediately report the alleged incident of abuse between the staff member and the resident when it occurred on the date in October 2023.

Sources: Review of CIS #2683-000014-23, the licensee's policy: #024 - Reporting of Abuse or Neglect, the licensee's investigation documents including related emails and interview with a staff member and other staff.
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WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, 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,

The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, received 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.

Rationale and Summary
Review of a resident's Treatment Administration Record (TAR) and progress notes on point click care indicated that on a date in August 2023, a resident had skin breakdown.

Further review of the resident's electronic and hard copy health records indicated that there were no initial wound assessment or weekly wound assessments including hard copy Weekly Skin Measurement Tools completed for the resident's skin breakdown.

In an interview with Inspector #622 on December 12, 2023, the Registered Practical Nurse (RPN) stated that there should be an initial wound assessment completed

when a resident's wound is first noted and weekly there-after using the Weekly Skin Measurement Tool.

The risk of not completing wound assessments is that wound complications may occur.

Sources: Review of the resident's electronic and hard copy health records and interview of the RPN and other staff.
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