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
May 7, 2021	2021_648741_0011	001764-21, 004150-21, 004186-21, 004897-21	Complaint

Licensee/Titulaire de permis

CVH (No. 3) 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 c/o Southbridge Care Homes Cambridge ON N3H 5L8

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

Chelsey Park
310 Oxford Street West London ON N6H 4N6

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

AYESHA SARATHY (741), CHRISTINA LEGOUFFE (730), MELANIE NORTHEY (563)

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): April 19-23, 26 and 27, 2021

The following complaints were inspected as a part of this inspection:

IL-87196-LO related to concerns regarding medication administration and nutrition and hydration
IL-88781-LO related to allegation of neglect, skin and wound care and bathing
IL-88399-LO related to resident to resident physical abuse
Critical Incident System (CIS) #2655-000009-21 was inspected as a complaint as it was related to the same concern as complaint IL-88399-LO

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), a Clinical Pharmacy Consultant, a physician, the Wound Care Champion and the Director of Resident Care (DRC).

As a part of the inspection, the Inspectors also reviewed relevant policies and procedures, clinical records of residents, and made observations of residents and medication administration pass.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 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 O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, 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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was assessed by a registered dietitian, who was a member of the staff of the home, when they exhibited altered skin integrity.

A resident exhibited altered skin integrity after being hit by another resident. The resident's skin was assessed by registered staff and the Wound Care Champion, but the resident was not assessed by the Registered Dietitian (RD).

A Registered Practical Nurse (RPN) said that registered staff were responsible to make a referral to the RD when residents exhibited skin impairment issues. The RPN said that a referral to the RD was missed for this resident. The RD said that they did not receive a referral for this resident and therefore, were not able to assess them when they exhibited altered skin integrity.

There was a risk that the resident's skin could have worsened because of not being assessed by the RD.

Sources: the Critical Incident Report (CIS) report; a Weekly Impaired Skin Integrity Assessment; the resident's progress notes; interviews with the PRN, RD and other staff. [s. 50. (2) (b) (iii)]

2. The licensee has failed to ensure that a resident, who experienced altered skin integrity, received skin assessments using a clinically appropriate assessment instrument and was reassessed weekly by a member of the registered nursing staff.

The home's policy said that areas of altered skin integrity would be assessed at least weekly using the Wound Assessment or Impaired Skin Integrity Assessment tools.

A resident had multiple areas of impaired skin integrity identified. Their electronic treatment administration record (eTAR) included orders to assess the areas weekly. Documentation showed that weekly assessments were missed for all of the areas for periods of two weeks or more. The Wound Care Champion (WCC) said that registered staff were responsible to complete and document assessments weekly once an area of skin impairment is identified, and that assessments were not documented for the resident as required.

There was increased risk of harm to the resident when areas of impaired skin integrity were not reassessed weekly.

Sources: "Skin and Wound Program: Wound Care Management" (Dated December 2019), Clinical records for the resident including progress notes, assessments, treatment administration records, and interviews with Wound Care Champion and other staff. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home and is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that interventions were implemented to minimize the risk of altercations and potentially harmful interactions between two residents.

A complaint and a Critical Incident System (CIS) report were received by the Ministry of Long-Term Care (MLTC) in relation to an incident where one resident hit another resident, resulting in an injury to the resident who was hit.

The resident who was the aggressor had a documented history of responsive behaviours. In the week prior to the incident, they had an increase in responsive behaviours, however, their plan of care included standard monitoring of the resident.

A Registered Practical Nurse (RPN) said that more frequent monitoring had not been discussed as a potential intervention for the resident. They said that because the resident did not have more frequent monitoring in place, the incident could not have been prevented as the Personal Support Workers (PSWs) on the floor would have been providing care to other residents at the time. The Director of Resident Care (DRC) said that constant supervision was considered for residents who showed signs of possible risk, and that it should have been put in place for this resident as they were a significant risk.

There was harm to a resident as a result of the home failing to put more frequent monitoring in place for the resident who displayed responsive behaviours and posed a risk to other residents.

Sources: Complaint report; CIS report; two residents' clinical records, including progress notes and plan of care; interviews with an RPN, DRC and other staff. [s. 54. (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 to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs administered to a resident were in accordance with the directions for use specified by the prescriber.

There was a reported complaint to the Ministry of Long-Term Care related to medication administration for a resident.

The physician orders included multiple medications that were to be administered to a resident at a particular time and if the administration of these medications was unsuccessful, the registered nursing staff may reattempt 10 hours later.

The electronic Medication Administration Record (eMAR) documented only the initial administration of these medications. There was no documentation for the medication when administered at the later time. The resident was documented to have refused the medications at at the first attempt on multiple dates with no documentation that they were reattempted 10 hours later.

The home's policy, documented that the eMAR electronic format was to be used to document all medications given to a resident.

A Clinical Pharmacy Consultant (CPC) verified that if registered nursing staff attempted the medications the first time and they were refused, there would be no other supply of medication to reattempt with 10 hours later. The CPC said that there was no other documented eMAR entry or time added to the existing eMAR entry and no other supply was dispensed by Medical Pharmacies.

The eMAR entry for the medications prescribed to the resident did not include two administration times and there was insufficient supply of medications for reattempt at when the resident refused medications at the first administration time. The resident was at risk of not receiving their medications as prescribed.

Sources: Extendicare Medication Management Policy RC-16-01-07, last updated December 2019, clinical record review for the resident, interviews with the Medical Pharmacies Clinical Consultant, a Registered Nurse and the Director of Resident Care. [s. 131. (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 to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for a resident provided clear direction related to the resident's care.

The Ministry of Long-Term Care (MLTC) received an anonymous complaint related to concerns about the resident not being able to have a supportive aid.

The resident's plan of care included an intervention that was unclear as it stated the supportive aid was not to be in place, and that it was in place. During multiple observations, the supportive aid was in place for the resident.

Personal Support Workers (PSWs), Registered Practical Nurses (RPNs) and the Wound Care Champion (WCC) said that the resident was not supposed to have the supportive aid but one PSW said that they provided the supportive aid to the resident because it was the resident's preference.

The Director of Resident Care (DRC) said that the resident was able to have the supportive aid against medical advice, but that staff were to monitor them for safety. They said that the plan of care did not provide clear direction for staff and that it should have said that the resident was using the supportive aid against medical advice and that staff were to conduct safety checks for it.

There was increased risk of harm to the resident as a result of the plan of care not providing clear direction related to the resident's supportive aid.

Sources: Clinical records for the resident, including progress notes and plan of care, observations, and interviews with the DRC and other staff. [s. 6. (1) (c)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident’s Power of Attorney (POA) was notified immediately upon the home becoming aware of an incident of abuse that resulted in physical injury to the resident.

The Ministry of Long-Term Care (MLTC) received a complaint from a resident’s POA with a concern that they were not notified immediately when the resident was hit by another resident and sustained an injury as a result. The resident’s progress notes indicated that their POA was contacted about the incident almost five hours after the incident occurred.

The home’s policy stated that disclosure of alleged abuse would be made to the resident/Substitute Decision Maker (SDM)/POA immediately upon becoming aware of the incident.

A Registered Practical Nurse (RPN) and the Director of Resident Care (DRC) said that the resident’s POA was not notified immediately after the incident occurred and should have been.

There was a risk of harm to the resident as a result of the home failing to notify the resident’s POA of the incident immediately.

Sources: Complaint report; Extendicare "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" RC-02-01-02, last updated June 2019; the resident’s progress notes; interviews with an RPN, the DRC and other staff. [s. 97. (1) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. There was a reported complaint to the Ministry of Long-Term Care related to medication administration for a resident.

The physician orders included multiple medications that were to be administered to a resident at a particular time and if the administration of these medications was unsuccessful, the registered nursing staff may reattempt 10 hours later.

The electronic Medication Administration Record (eMAR) documented the resident as having refused the medications at the first administration time on multiple dates with no documented reattempt 10 hours later.

A Registered Nurse (RN) verified that the day shift registered staff would pour the medications at the first administration time into a clear medication cup for administration and if the resident refused, the medications would be stored in the resident's labelled "cubby" in the medication cart until the reattempt 10 hours later. The RN verified the medications were not kept in their original labeled strip packaging from pharmacy and should have been.

The home's medication policies documented the nurse was to verify that the contents of the resident's multi-dose medication strip/pouch matched the resident's eMAR for resident name, medication(s), brand and generic name, strength, description, quantity and administration date, day and time. The medication process was to comply with all applicable professional standards of practice, accreditation standards, provincial legislation and pharmacy policies to ensure safe, effective and ethical administration of medications. The policy explained that medications were to be kept in their original labeled container(s) or package(s) provided by the pharmacy until administered to the

resident or destroyed.

The Director of Resident Care verified that all medications for all residents were to remain in their original labeled packaging from pharmacy until administered or destroyed.

There was risk of a medication error when the resident's medications were poured from their labeled strip pack and kept unlabeled in the medication cart between the first administration refusal and the reattempt 10 hours later. Registered nursing staff could not ensure that the resident's medications corresponded identically with the resident's eMAR prior to administering the medications.

Sources: clinical record review for the resident, Extendicare Multi-Dose System Policy RC-16-01-25, last updated December 2019, Extendicare Medication Management Policy RC-16-01-07, last updated December 2019, interviews with the Medical Pharmacies Clinical Consultant, a Registered Nurse and the Director of Resident Care. [s. 126.]

Issued on this 11th day of May, 2021

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

Original report signed by the inspector.