Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Aug 12, 2016;	2016_397607_0013 (A1)	025557-15, 012421-16, 003256-16	Critical Incident System

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Warkworth Place
97 Mill Street P.O. Box 68 Warkworth ON K0K 3K0

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

JULIET MANDERSON-GRAY (607) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has requested changes to evidence in WN# 1, be amended - related to Log #003256-16.

Issued on this 12 day of August 2016 (A1)

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

Original report signed by the inspector.

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

JULIET MANDERSON-GRAY (607) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): June 8, 9 & 10, 2016.

During this Critical Incident Inspection, the following intakes were reviewed and inspected upon #02557-15, 012421-16 and 003256-16.

Summary of the Intakes:

1) #025557-15 - regarding staff to resident alleged abuse.

2) #012421-16 - regarding fall resulting transfer to a hospital.

3) #003256-16 – regarding resident to resident alleged sexual abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Clinical Coordinator, Registered Nurses (RN), a Physiotherapist Assistant (PTA) and Personal Support Workers (PSW).

During the course of this inspection the inspector reviewed clinical records, observed staff to resident interactions, reviewed home's investigations notes (specific to identified Critical Incident Reports), reviewed home specific polices related to Resident Abuse Prevention, Falls, Lifts and transfer, Responsive behaviours, Minimizing of restraints, reviewed staff training records and manufacturer's instructions related to lifts.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **7 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	Legendé 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. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

Findings/Faits saillants :

(A1)
1. s. 6. (2) The licensee shall ensure that the care set out in the plan of care is

based on an assessment of the resident and the needs and preferences of that resident specifically related to resident #006.

Related to Log #025557-15 for resident #006:

The home submitted a Critical Incident Report (CIR) on an identified date, for an incident related to staff to resident alleged abuse involving resident #006. The critical incident identified the following:

Resident #006 is dependent on staffs for activities of daily living. On the identified date of the incident, PSW #109 approached the resident who was in bed, whom recently experienced a decline in health, to offer breakfast in his/her room. The resident requested an alternate choice to the meal the PSW had brought in. PSW #110 overheard PSW #109 make an inappropriate comment to the resident when he/she made the request.

An interview with the DOC confirmed that the expectations is if someone request something, the home does its best to accommodate his or her needs, and in the case of resident #006 PSW #109 response did not indicate this.

Therefore, the licensee has failed to ensure that the care set out in the plan of care is based on an assessment of resident #006 needs and preferences. [s. 6. (2)]

2. The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Related to Log #003256-16 for resident #004 and resident #005:

A Critical Incident Report (CIR) was received from the home and indicated that on an identified date, resident #004 approached resident #005 after breakfast, and proceeded to touch the resident inappropriately.

Resident #005 uses an assistive device to ambulate, but requires staff assistance with ambulation. Prior to the incident on the identified date, resident #004 ambulates by his/herself around the home using this an assistive device. With previous incidents, the resident was ambulatory with the use of another assistive device and had multiple incidents of inappropriate behaviours.

A review of the plan of care for resident #004 with an identified date indicated that

the resident had a history of ongoing inappropriate behaviours towards other residents. A review of the behaviour assessment tool (BAT) revealed that one of resident #004's trigger was being left alone with other residents. The intervention in place identified that resident #004 was not to be left alone with other residents.

An interview with RN #104 indicated that resident #005 cannot move from one position to another without the assistance of staff and is unable to give consent.

Therefore, on an identified date, the licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified, as resident #004 was being left alone with another resident. [s. 6. (7)]

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 ensuring that the care set out in the plan of care is based on an assessment of resident #006's needs and preferences,
Will ensure that care set out in the plan of care is provided to the resident #004 as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that safe transferring techniques was used when assisting residents, specifically related to resident #001.

Related to Log #012421-16:

A Critical Incident Report was received from the home on an identified date, indicating that resident #001 was being transferred by PSW #101 with a transfer device. PSW #101 attempted to manoeuvre the transfer device during the transfer causing it to catch on the threshold of the raised flooring. At the same time, the resident leaned forward and as a result, the transfer device fell forward resulting in the resident sustaining an injury. The PSW released the resident from the transfer device after the resident had fallen.

A review of the hospital consultation notes with an identified date revealed that resident #001 sustained multiple injuries as a result of the fall.

A review of the plan of care for resident #001 at the time of the incident indicated the resident required two people extensive assistance with transferring as the resident was at risk for falls.

An interview with PSW #101 confirmed that he/she transferred the resident by him/herself, with no other staff present and had moved away from the resident when device the resident was being transferred with tipped, causing the resident to fall.

An interview with the DOC confirmed that the staff did not follow plan of care related to transferring of the resident at the time the resident fell, and the transfer of the resident should have been done by two staff.

Therefore, PSW #101 failed to use safe transferring and positioning techniques when assisting resident #001 with transferring, resulting in the resident falling and sustaining multiple injuries. [s. 36.]

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 ensure that safe transferring techniques are used when assisting resident #001, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that training was provided to all staff who apply physical devices or who monitor residents restrained by a physical device, including:
application of these physical devices, use of these physical devices, and potential dangers of these physical devices.

Related to Log # 003256-16:

A review of the education records revealed that eighteen percent of direct care staff did not received training on how to minimize restraint of a resident in 2015.

An interview with Administrator indicated that all direct care staff did not receive this training because of the transition between the changeover of policies between the home and the managed Cooperation as well as the home had overlooked the required training of the staffs. [s. 221. (1) 5.]

2. The licensee has failed to ensure that all staff who provide direct care to residents, receive training relating to abuse recognition and prevention annually.

Related to Log #025557-15 for resident #006:

A review of the education records revealed that eighteen percent of staff did not received training on Abuse recognition and prevention in 2015.

An interview with the Administrator indicated that all staff did not receive this training because of the transition between the home and the managed Cooperation as well as the home had overlooked the required training of the staffs. [s. 221. (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 training is provided to all staff who apply physical devices or who monitor residents restrained by a physical device, including:
application of these physical devices, use of these physical devices, and potential dangers of these physical device,

will ensure that all staff who provide direct care to residents, receive training relating to abuse recognition and prevention annually, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with for resident #001 and #003.

Related to Log #012421-16:

A Critical Incident Report was received from the home on an identified date, indicating that resident #001 was being transferred by PSW #101 with a transfer device. PSW #101 attempted to manoeuvre the transfer device during the transfer causing it to catch on the threshold of the raised flooring. At the same time, the

resident leaned forward and as a result, the transfer device fell resulting in the resident sustaining an injury. The PSW to released the resident from the transfer device after the resident had fallen.

During the inspection, the resident sample was extended to include resident #003 in relation to falls.

A review of the progress notes indicated that on an identified date resident #003 had been reaching for the bottom drawer of his/her dresser when the resident had a hard time pulling out the drawer, resulting in him/her falling.

A review of the home's Post Fall Assessment Policy # RESI-10-02-02, with an identified date, directs:

Procedures:

1. Complete a post fall assessment after each fall a resident experience within the first 24 hours.

A review of the clinical records failed to identify that a post fall assessment was completed within 24 hours for resident #001 and #003 on or after the identified dates of the falls.

An interview with RN #104 confirmed that an assessment related to post fall for resident #001or #003 was not completed on or after the identified dates.

An interview with the Administrator confirmed that the home's expectation is that staff completes post fall assessment.

Therefore, the home did not follow its Post Fall Assessment policy # RESI-10-02-02 for resident #001 and #003 by not completing these assessments. [s. 8. (1) (a), s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that consent was obtained for resident #004 in the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living included in a resident's plan of care only if:

- The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker (SDM) of the resident with authority to give that consent.

Related to Log # 003256-16:

A Critical Incident Report (CIR) was received from the home and indicated that on an identified date, resident #004 had approached resident #005 after breakfast and proceeded to touch the resident inappropriately.

A review of resident #004's current care plan indicated that the resident had interventions in place for a safety device that the resident is unable to remove. The plan of care also indicates that the device is sometimes placed in an angled position.

An interview with the Physiotherapist Assistant (PTA) #108 confirmed that the resident assistive device is sometimes placed in an angled position and that the resident is unable to move when the device is in this position.

A review of the clinical records failed to identify that there was consent in place from the resident or the resident Substitute Decision Maker (SDM) consenting for staff to place the assistive device in an angled position.

An interview with RN #107 and the DOC confirmed that there is no consent in place indicating that the resident assistive device should be placed in an angled position.

Therefore the home has failed to ensure that resident #004 has consent in place that was obtained for PASD by his SDM specifically related to placing the assistive device in angled position. [s. 33. (4) 4.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident:

(i) names of all residents involved in the incident,
(ii) names of any staff members or other persons who were present at or discovered the incident, and
(iii) names of staff members who responded or are responding to the incident?

Related to log # 025557-15 for resident #006:

The home submitted a Critical Incident Report (CIR) on an identified date, for an incident related to staff to resident alleged abuse involving resident #006. The critical incident identified the following:

Resident #006 is dependent on staffs for activities of daily living. On the identified date of the incident, PSW #109 approached the resident who was in bed, whom recently experienced a decline in health, to offer breakfast in his/her room. The resident requested an alternate choice to the meal the PSW had brought in. PSW #110 was overheard by PSW #109 make an inappropriate comment to the resident when he/she made the request.

A review of the CIR failed to identify the name of the staff who was involved with the incident related to resident #006.

An interview with the Administrator indicated that CIR did not include the name of PSW #109 who was involved with the incident.

Therefore the home has failed to ensure that the report to the Director included the name of the staff member who was involved in the incident specifically related to resident #006. [s. 104. (1) 2.]

WN #7: 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:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written report include a description of the individuals involved in the incident, including:

i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident?

A Critical Incident Report was received from the home on an identified date, indicating that resident #001 was being transferred by PSW #101 with a transfer device. PSW #101 attempted to manoeuvre the transfer device during the transfer causing it to catch on the threshold of the raised flooring. At the same time, the resident leaned forward and as a result, the transfer device fell forward resulting in the resident sustaining an injury. The PSW released the resident from the transfer device after the resident had fallen.

A review of the investigation notes revealed that PSW #111, #112 and #113 responded to the above incident.

A review of the above identified CIR failed to identify the names of above three identified PSWs who responded to the incident involving resident #001.

An interview with the Administrator confirmed that above identified CIR did not include the names of three PSWs who responded to the incident involving resident #001. [s. 107. (4) 2.]

Issued on this 12 day of August 2016 (A1)

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

Original report signed by the inspector.