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 26, 2020	2020_838760_0006	021574-19, 023186-19, 023988-19, 002149-20	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) 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

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

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

JACK SHI (760), SAMI JAROUR (570)

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): February 25, 26, 27, 28, and March 2, 3, 4, 5, 6, 9, 10, 11, 12, 13, 2020

The following intakes were completed in this critical incident system inspection:
Log related to a suspected improper transfer resulting in injury.
Log related to allegations of staff to resident abuse.
Log related to a suspected improper transfer resulting in injury.

A follow up to Compliance Order (CO) #001, s. 19, related to resident abuse, issued under inspection #2019_655679_0028, on December 6, 2019, with a compliance date of March 10, 2020, was inspected.

A Complaints inspection #2020_838760_0005 was conducted concurrently with this Critical Incident Systems inspection.

PLEASE NOTE: A WN related to s. 6 (7) was identified in this inspection and has been issued in Inspection Report #2020_838760_0005 dated on May 26, 2020, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Behavioural Supports Ontario Personal Support Worker (BSO PSW), Housekeepers, Laundry Aides, Director of Clinical Care (DOCC), Housekeeping Manager, Environmental Supervisor, Director of Care (DOC), Administrator, residents, and Substitute Decision Makers (SDM).

During the course of the inspection, the inspector(s) conducted observations, record reviews and interviews.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Training and Orientation

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

- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2019_655679_0028	760

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. 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policies, that the policy was complied with.

In accordance with Ontario Regulation 79/10 s. 50. (2) (b), every licensee of a long-term care home shall ensure that, 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.

A review of the licensee's policy, titled Skin and Wound Program: Prevention of Skin Breakdown, last updated December 2019, indicated the following:
- Nurse/Interdisciplinary team were to promptly assess/address all skin concerns reported by the care staff; determine the root cause of the skin injury and put in place preventative strategies to avoid reoccurrence or further injury, document changes in resident's skin condition in the progress notes and wound records where applicable; Notify resident/Power of Attorney (POA)/SDM/family of any or new worsening skin/wound conditions and interventions in place.

- Care staff were to observe residents' head to toe skin condition during the provision of care; document altered skin integrity in the Daily Care Record or electronic equivalent; promptly report verbally any changes (e.g. redness, bruises, skin tears) to the nurse.

A Critical Incident Report (CIR), was submitted to the Director related to the incompetent care of resident #001. The CIR indicated that the SDM of resident #001 reported to RPN #119 that resident #001 had an identified altered skin integrity. RPN #128 informed the SDM that there was no documentation completed for the identified altered skin integrity.

Inspector #570 reviewed the home's internal investigation file related to the CIR. In the investigation, RPN #119 had indicated to the home that they had forgotten to check on resident #001's altered skin integrity when it was reported by the resident's SDM.

Inspector #570 reviewed progress notes for resident #001. The review indicated that RPN #128 documented that the resident's SDM reported the resident had an altered skin integrity issue in an identified location of their body. RPN #128 assessed the area and initiated continued monitoring of this area, using the electronic Treatment Administration Record (E-TAR) system.

A review of E-TAR for resident #001 indicated to monitor the area of altered skin integrity until healed.

Inspector #570 reviewed electronic records for resident #001. The review did not indicate a report, nor a skin assessment was completed for resident #001's altered area of skin integrity when it was reported by the SDM .

During separate interviews by Inspector #570 with RPN #106 and RN #107, they indicated that the practice in the home is to ensure that once registered staff becomes aware of an altered skin integrity issue, it should be assessed and documented electronically which also includes completing a skin assessment and notification of the SDM of the resident. During the interview, RN #107 indicated when they were first notified of resident #001's altered skin integrity issue, they did not assess the resident. RN #107 further indicated that when they assessed the resident at a later period, they could not find any altered skin integrity issues.

In an interview with the DOC, they indicated to Inspector #570, that RPNs #119 and #128 did not follow the home's policy when RPN #119 did not assess resident #001's altered skin integrity with no documentation noted; and RPN #128 did not complete a

skin assessment and did not initiate an electronic report.

The licensee's policy, titled Skin and Wound Program: Prevention of Skin Breakdown was not complied with when resident #001's altered skin integrity was not assessed. [s. 8. (1) (b)]

2. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policies, that the policy was complied with.

A CIR was submitted to the Director related to the incompetent care of resident #002. The CIR indicated indicated RPN #122 was notified that resident #002 sustained an altered skin integrity issue on an identified location on their body. After a period of time, the resident was assessed by the physician and further medical assessments were rendered. Skin and pain assessments were completed and the resident's SDM was notified at that point.

Inspector #570 reviewed the home's internal investigation file related to the CIR. In the investigation, RPN #122 had indicated to the home that they had seen identified concerns related to the altered skin integrity and put it in the doctor's book but did not document in their chart, did not report to the supervisor and did not notify resident #002's SDM.

Inspector #570 reviewed resident #002's clinical chart. The review indicated the identified concerns related to the altered skin integrity was assessed by the physician a few days after RPN #122 first discovered it. The record review indicated no skin assessment was completed, no monitoring and no interventions were put in place until a few days after the resident was seen by the physician.

In an interview by Inspector #570 with RPN #122, they acknowledged that when PSW staff first reported that resident #002 had an altered skin integrity issue, RPN #122 wrote a note in the doctor's book to assess the resident. RPN #122 acknowledged they did not initiate a report, did not complete skin assessment, did not inform their supervisor, and did not notify the SDM. RPN #122 further indicated that they worked a number of shifts between when resident #002's altered skin integrity was first identified to when the doctor assessed the resident and did not do any follow up documentations between that period. The RPN indicated that they should have called the supervisor for directions.

In an interview by Inspector #570 with RN #120, they indicated they became aware of the resident's altered skin integrity by reading the report book on the date that the doctor assessed the resident. RN #120 indicated they completed a skin assessment for the resident when they first became aware of the issue. The RN indicated that RPN #122 should have called the doctor and informed the supervisor on duty for directions.

In an interview by Inspector #570 with the DOC, they confirmed the skin and wound policy was not followed when no skin assessment was completed, no pain assessment was completed, and the resident's SDM was not notified when PSW staff first reported resident #002's altered skin integrity to RPN #122. The DOC further indicated that none of PSW staff documented any skin observations for resident #002 related to their altered skin integrity.

The licensee's policy, titled Skin and Wound Program: Prevention of Skin Breakdown was not complied with when resident #002's altered skin integrity was not assessed. [s. 8. (1) (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 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 (b) is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that an allegation of abuse and improper treatment of resident #006 by staff was reported immediately to the Director.

A CIR was submitted by the home, related to allegations of staff to resident verbal and physical abuse that occurred in a previous period and was captured by a video camera.

A record review indicated resident #006's SDM sent emails to the home at various dates and times, though all within a similar time frame, in relation to footage of the allegation of abuse and improper treatment of resident #006.

An interview with DOC #114 indicated that these incidents occurred all around the same time and it was initially reported by resident #006's SDM to the home’s previous DOCC, Administrator #130 and programs manager.

Administrator #130 indicated they were in the progress of transitioning into the new administrator of the home when they became aware of this allegation of abuse with resident #006. Administrator #130 indicated that the previous DOCC of the home was in charge of the investigation and did not follow the home’s expectations when it came to reporting this allegation to the Director.

DOC #114 stated that the CIR was submitted to the Director after a period of time passed from when these incidents occurred and when the home became aware of them. DOC #114 and Administrator #130 indicated that this incident of alleged staff to resident abuse and incompetent treatment should have been reported to the Director immediately.

The licensee failed to ensure that the allegation of abuse and improper treatment of resident #006 was immediately reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that when resident #006 was taking any drug, there was documentation of the resident's response and the effectiveness of the drugs.

A CIR was submitted by the home, related to allegations of staff to resident verbal and physical abuse and incompetent treatment that occurred in a previous period and was captured by a video camera.

A record review of the progress notes for resident #006 indicated RPN #128 documented an administration of an as-needed medication to the resident, as per their request. After a period of time, RPN #128 documented an effectiveness with the as-needed medication and followed up with a documented reassessment. Later on that same shift, RPN #128 documented another administration of the same as-needed medication for resident #006 but did not document its effectiveness on their shift; the registered staff who worked the next shift documented the effectiveness was unknown.

A review of the home's policy titled, "PRN Medications", indicates that staff are to document the reason for administration and its effectiveness on the electronic Medication Administration Record (eMAR).

Inspector #760 and DOCC #125 reviewed the video footage submitted by resident #006's SDM without audio due to technical issues. RPN #128 and resident #006 appeared gesture at the RPN and a period after, RPN #128 proceeds to provide resident #006 with their medication. DOCC #125 stated RPN #128 did not go back into resident #006's room to reassess them.

RN #117 indicated during their interview that the home's expectations and policy indicates that after 30-60 minutes passed since the administration of an as-needed pain medication, a follow up reassessment needs to be performed with the resident.

An interview with DOC #114 indicated that the home's expectations for post administration of an as-needed medication would be to go back into the resident's room and involve the resident in the assessment and document their response accordingly. DOC #114 stated that RPN #128 did not go back into resident #006's room after administering the as-needed medication and stated that the footage in the video did not match with what RPN #128 documented in their progress note. DOC #114 confirmed RPN #128 failed to document resident #006's response and effectiveness of taking an as-needed medication.

The licensee failed to ensure that resident #006's response and effectiveness of taking an as-needed pain medication was documented. [s. 134. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident is taking any drug or combination of drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #006 was protected from verbal and physical abuse from PSW #118 and PSW #127.

A CIR was submitted by the home, related to allegations of staff to resident abuse that occurred in a previous period and was captured by a video camera.

A record review of resident #006's written plan of care around the time of these incidents indicates that the resident demonstrates responsive behaviours. The interventions listed indicate to have staff respond accordingly depending on their responsive behaviours and this included responding to their call bell promptly. The interventions also included to ensure that two staff were present for care at all times.

A review of the home's investigation notes related to this incident indicated that PSW #118 was responded to resident #006's call bell after multiple previous calls. PSW #118 went into their room and questioned the resident's use of the call bell. DOC #114 indicated that PSW #118's body language was inappropriate and slammed the resident's door after they left. PSW #118 was disciplined and apologized for their actions.

A review of the home's investigation notes related to PSW #127 indicated that the resident was telling PSW #127, "two staff, two staff" and was attempting to refuse the care from PSW #127 but they held stopped them from refusing and proceeded to provide care to the resident.

Inspector #760 and DOCC #125 reviewed the video footage from PSW #118 and PSW #127 and was unable to hear the communication between the staff members and resident, due to technical issues. Inspector observed PSW #118 walking towards resident #006 and made a gesture at the resident. According to DOCC #125, during this encounter, PSW #118 made a remark to the resident about the use of their call bell. Inspector also observed PSW #127 preparing the care for resident #006, but resident #006 gestured to PSW #127, indicating they did want the care to proceed, as they wanted two staff members present. PSW #127 ignored this request from resident #006 and continued with the care by physically restraining resident #006.

During an interview with Inspector #760, PSW #118 indicated they attended to resident #006's room multiple times during their shift. During one of those encounters, they pointed at the resident and slammed the resident's door when they left. PSW #118 stated that this was inappropriate interaction with resident #006.

DOC #114 indicated in their interview that the home's expectations was for staff to answer a resident's call bell right away and when they enter their room, the staff should start by introducing themselves and attempt to figure out what the resident needs are and provide the required assistance. DOC #114 confirmed that when PSW #118 went into resident #006's room after multiple previous calls, they questioned resident #006's use of their call bell and turned off the lights and slammed the door when they left. Furthermore, DOC #114 confirmed when resident #006 demonstrated to PSW #127 that they did not want to proceed with their care because they wanted two staff present, PSW #127 continued with their care and physically restrained the resident. DOC #114 confirmed that the home failed to ensure resident #006 was protected from verbal and physical abuse from PSW #118 and PSW #127.

The licensee failed to ensure resident #006 was protected from verbal and physical abuse from PSW #118 and PSW #127. [s. 19. (1)]

Issued on this 5th day of June, 2020

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

Original report signed by the inspector.