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

Central East District
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Original Public Report

Report Issue Date: March 22, 2024

Inspection Number: 2024-1147-0001

Inspection Type:
Complaint
Critical Incident
Follow-Up

Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)

Long Term Care Home and City: Hope Street Terrace, Port Hope

Lead Inspector	**Inspector Digital Signature**
Chantal Lafreniere (194)	Chantal D Lafreniere Digitally signed by Chantal D Lafreniere Date: 2024.04.03 10:28:23 -04'00'

Additional Inspector(s)
Julie Mercer (000737)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 29, and March 1, 4, 5, 8, 11, 12, 13, 2024.
The inspection occurred offsite on the following date(s): March 7, 8, 12, 13, 2024.

The following intake(s) were inspected:
-A Critical Incident Report (CIR) related to a COVID-19 outbreak.
-Two CIR's related to an allegation of staff to resident abuse of two residents.
-A CIR related to a resident fall that resulted in injury.
-Follow-Up Order related to FLTCA, 2021, s. 77(1).
-An anonymous complaint related to Personal Support Worker qualifications.

-An anonymous complaint related to a resident's responsive behaviours, assessments, and an allegation of resident neglect.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1147-0003 related to FLTCA, 2021, s. 77 (1) inspected by Chantal Lafreniere (194)

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

Resident Care and Support Services
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
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,
(c) clear directions to staff and others who provide direct care to the resident.

The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provide direct care to the resident, specifically related to personal alarms and the use of adaptive equipment.

Rationale and Summary
A Critical Incident Report (CIR) was received by the Director related to a resident fall that resulted in injury.

Review of the resident's written plan of care indicated the use of a personal alarm on a stationary chair in their bedroom. The resident's written plan of care did not indicate that the resident used adaptive equipment on an as needed (PRN) basis.

A Personal Support Worker (PSW) confirmed that the resident used the adaptive equipment for a short period of time but no longer required the use of it.
A Registered Practical Nurse (RPN) confirmed that the resident does not require the use of adaptive equipment.

A PSW and the Fall's Lead, both confirmed that the resident does require the use of adaptive equipment on a PRN basis.

Inspector observed a sign in the resident's bedroom that indicated staff were to check that the resident's personal alarm was in place only when the resident was using the stationary chair in their bedroom.

Inspector and a PSW located the resident seated in a stationary chair, outside of their room, with their adaptive equipment located beside them, and neither chair had a personal alarm in place for the resident.

Review of the resident's electronic records, for a specific period of time, indicated a PSW task in Point of Care (POC) to ensure that the resident's personal alarm was in

place on every shift. Review of the resident's POC task confirmed multiple dates/times of PSW documentation that indicated that the resident's personal alarm checks were "not applicable".

A PSW, an RPN, the Fall's Lead, and the Assistant Director of Care (ADOC), all confirmed that the resident was to have a personal alarm in place, wherever the resident was seated, at all times.

The ADOC also confirmed that PSWs were to ensure that the resident had a personal alarm in place on their chair on every shift. The ADOC confirmed that there were inconsistencies between the sign in the resident's bedroom, the written plan of care, and the POC task for the resident's personal alarm, which provided staff with unclear direction in relation to the resident's needs.

Failure to ensure that a resident's written plan of care set out clear directions to staff and others who provide direct care to the resident, specifically related to personal alarms and the use of adaptive equipment, placed the resident at increased risk of falls.

Sources: Review of CIR, the home's "Falls Prevention and Management Program" Policy, a resident's electronic records, Inspector observations, and interviews with staff. [000737]

WRITTEN NOTIFICATION: PLAN OF CARE-DUTY TO COMPLY WITH PLAN

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

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.

The licensee failed to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan.

Rationale and Summary
A CIR was received by the Director related to a resident fall resulting in injury.

Review of the resident's written plan of care indicated falls prevention interventions were to be implemented.

Inspector and a PSW located the resident seated in a stationary chair, outside of their room, with their adaptive equipment located beside them, and neither had an alarm in place for the resident.

A PSW, an RPN, the Fall's Lead and the ADOC, all confirmed that the resident was to have a personal alarm in place, wherever the resident was seated, at all times.

An RPN and the ADOC, both confirmed that diagnostic testing was not conducted post-fall as directed in the written plan of care.

The ADOC confirmed that another diagnostic test, as directed in the resident's written plan of care, was not conducted after two separate falls.

Review of the resident's electronic records confirmed that two different diagnostic tests were not conducted after two separate falls.

Failure to ensure that the care set out in a resident's plan of care was provided to the resident as specified in the plan, placed the resident at increased risk for subsequent falls.

Sources: Review of CIR, the home's "Falls Prevention and Management Program" Policy, a resident's electronic records, Inspector observations, and interviews with staff. [000737]

WRITTEN NOTIFICATION: DUTY TO PROTECT

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

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (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.

O. Reg. 246/22 s. 2 defines "physical abuse" as the use of physical force by anyone other than a resident that causes physical injury or pain.

The Licensee failed to protect a resident from abuse by staff.

Rationale and Summary

A CIR was submitted to the Director for allegations of physical abuse involving a PSW towards a resident.

The Resident reported to their family that they had been abused by staff. The family reported the incident to the Nurse Practitioner, who reported the incident to the Clinical Consultant (CC), who was working as the Director of Care (DOC). The resident reported that a PSW had been aggressive while providing personal care, specifically during repositioning, which caused the resident pain.

The resident reported that this occurred multiple times during care by the same PSW.

At the time of the inspection the resident was unable to recall specific details of the incident. Review of the home's internal investigation notes and the resident's electronic records confirmed details surrounding the incident.

Review of the resident's electronic records, during a specific period of time, indicated documentation that a PSW had aggressively repositioned the resident, which caused the resident pain. The resident stated that this specific PSW was always aggressive with their care, particularly while repositioning. The resident reported another incident whereby, the same staff member was aggressive while assisting to transfer the resident, which caused the resident pain.

The CC confirmed that they had been responsible for completing the homes internal investigation into the allegation involving the resident. The CC confirmed that two PSW's were interviewed following the allegations of abuse. The CC confirmed that the homes internal investigation concluded that the allegations of abuse involving the resident were founded and that the alleged PSW had denied all allegations of abuse.

The witness PSW's statement indicated that they assisted the alleged PSW with the resident's care and then asked if they needed any further assistance. The alleged PSW stated that they did not need assistance. The witness PSW indicated in their statement that they were aware that the resident was getting upset when they were leaving. The witness PSW was asked what they did about the situation, they replied they did nothing, and stated that they should have reported it.

The licensee failed to protect a resident from abuse when the alleged PSW provided care which resulted in pain, and when the witness PSW failed to immediately report the suspicions of witnessed abuse.

Sources: Review of CIR, licensee's internal abuse investigation document's, a resident's electronic records and interview with staff. [194]

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO THE DIRECTOR

NC #004 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.

O. Reg. 246/22 s. 2 defines "physical abuse" as the use of physical force by anyone other than a resident that causes physical injury or pain.

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

Rationale and Summary
A CIR was submitted to the Director for allegations of abuse by a PSW towards a resident.

The resident reported to their family, that they had been abused by staff. The resident reported that a PSW had been aggressive while providing care, specifically

during repositioning, which caused the resident pain. The resident reported that this occurred multiple times during care by the same PSW.

Review of the resident's electronic records, for a specific period of time, indicated documentation that a PSW had aggressively repositioned the resident, which caused the resident pain. The resident stated that this specific PSW was always aggressive with their care, particularly while repositioning. The resident reported another incident whereby, the same staff member was aggressive while assisting to transfer the resident, which caused the resident pain.

During the home's internal investigation into the allegations of abuse of the resident, two PSW's were interviewed, as they were providing care to the resident.

The witness PSW's statement indicated that they assisted the alleged PSW with the resident's care and then asked if they needed any further assistance. The alleged PSW stated that they did not need assistance. The witness PSW indicated in their statement that they were aware that the resident was getting upset when they were leaving. The witness PSW was asked what they did about the situation, they replied they did nothing, and stated that they should have reported it.

The CC confirmed that the homes internal investigation concluded that the allegations of abuse involving the resident were founded. CC indicated that when they interviewed the witness PSW, they confirmed that they should have reported the incident to management. The allegations of abuse were reported to the Director several days after the incident.

The licensee failed to immediately report abuse to the Director, when a PSW failed to immediately report the suspicions of abuse witnessed while providing care to a resident.

Sources: Review of CIR, the licensee's internal abuse investigation documents, and interview with staff. [194]

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (3)
Falls prevention and management
s. 54 (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 246/22, s. 54 (3).

The licensee has failed to ensure that equipment, supplies, devices, and assistive aids were readily available at the home.

Rationale and Summary
A CIR was received by the Director related to a resident fall resulting in injury.

Review of the resident's written plan of care indicated falls prevention interventions were to be implemented.

A PSW, an RPN, the Fall's Lead and the ADOC, all confirmed that the resident was to have a personal alarm in place, wherever the resident was seated, at all times.

The ADOC confirmed that the resident had a subsequent fall out of their adaptive equipment.

Review of the resident's electronic records on a specific date, indicated nursing documentation that indicated the resident's personal alarm was not operational and staff were to use the resident's alternate alarm in the interim.

A PSW confirmed that on a specific date, the charge nurse informed them that the resident's personal alarm was not operational and to use the resident's alternate alarm instead.

The ADOC confirmed that they were unaware that the resident's personal alarm was not operational on a specific date. The ADOC confirmed that they had previously ordered additional alarms but had not received them.

Inspector and a PSW located the resident seated in a stationary chair, outside of their room, with their adaptive equipment located beside them, and neither chair had an alarm in place for the resident.

Failure to ensure that alarms were readily available at the home for a resident, placed the resident at increased risk for falls and potential injury.

Sources: Review of CIR, the home's "Falls Prevention and Management Program" Policy, a resident's electronic records, Inspector observations, and interviews with staff. [000737]

WRITTEN NOTIFICATION: PAIN MANAGEMENT

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee's pain management program must, at a minimum provide for monitoring of resident's responses to and the effectiveness of the pain management strategies.

As directed under O. Reg 246/22 s. 11 (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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system, (b) is complied with.

Specifically, the home's "Pain identification and management" Policy indicated that a comprehensive pain assessment was to be completed when breakthrough pain medication was used for three consecutive days.

Rationale and Summary
During inspection of a complaint involving a resident's medical incident, it was noted that the resident was having pain and required the use of PRN pain medication.

Review of the resident's electronic records, for a specific period of time, confirmed that PRN pain medication was administered to the resident for three consecutive days on two separate occasions.

The ADOC confirmed that resident pain assessments were required on admission, with onset of new disease, and when PRN pain medications were administered to a resident for three consecutive days.

A Registered Nurse (RN) confirmed that pain assessments were required to be completed if the resident was provided with PRN pain medication over three consecutive days.

Review of the resident's electronic records, confirmed that no comprehensive pain assessment was completed.

Failure to ensure that the pain management program, specifically that pain

assessments were completed as required, placed the resident at increased risk of unmanaged pain.

Source: A resident's electronic records, "Pain Identification and Management" Policy, interviews with staff. [194]

WRITTEN NOTIFICATION: POLICY TO PROMOTE ZERO TOLERANCE

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 103 (d)
Policy to promote zero tolerance
s. 103. Every licensee of a long-term care home shall ensure that the licensee's written policy under section 25 of the Act to promote zero tolerance of abuse and neglect of residents,
(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation.

The licensee's written policy under section 25 of the Act to promote Zero Tolerance of abuse and neglect of residents, identified the manner in which allegations of abuse and neglect were to be investigated, including who will undertake the investigation and who will be informed of the investigation.

As directed under O. Reg 246/22 s. 11. (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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system, (b) is complied with.

Specifically, the home's "Zero Tolerance of Resident Abuse and Unlawful Conduct" Policy directed the home to complete the Southbridge Internal Incident Reporting form.

Rationale and Summary
A CIR was submitted to the Director for allegations of physical abuse by a PSW towards a resident.

The resident reported to their family, that they had been abused by staff. The resident reported that a PSW had been aggressive while providing care, specifically during repositioning, which caused the resident pain. The resident reported that this occurred multiple times during care by the same PSW.

The inspector was provided with a copy of the home's internal investigation, which included two educational certificates, some handwritten notes that were dated but not signed for interviews related to the incident.

The CC confirmed that the Internal Incident Reporting Form was not completed.

Failure to ensure that the homes "Zero Tolerance of Abuse" Policy was complied with, placed the home and the resident at risk of ongoing abuse practices.

Sources: Review of CIR, the home's "Zero Tolerance of Resident Abuse and Unlawful Conduct" Policy, the licensee's internal abuse investigation documents, and interviews with staff. [194]

WRITTEN NOTIFICATION: POLICE NOTIFICATION

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 105

Police notification

s. 105. Every licensee of a long-term care home shall ensure that the appropriate police service is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 246/22, s. 105, 390 (2).

The licensee failed to ensure that the appropriate police service was immediately notified of any alleged, suspected or witnessed incident of abuse of a resident that the licensee suspected may constitute a criminal offence.

Rationale and Summary

A CIR was submitted to the Director for allegations of physical abuse by a PSW towards a resident.

The resident reported to their family, that they had been abused by staff. The resident reported that a PSW had been aggressive while providing care, specifically during repositioning, which caused the resident pain. The resident reported that this occurred multiple times during care by the same PSW.

Review of the home's " Zero Tolerance of Resident Abuse and Unlawful Conduct" Policy directed that the home shall ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse that resulted in harm or risk of harm to a resident.

The CC confirmed that the homes internal investigation concluded that the allegations of abuse involving the resident were founded. The CC confirmed that the police were not notified.

Failure to ensure that the appropriate police service was immediately notified of any alleged, suspected or witnessed incident of abuse of a resident, placed the resident at increased risk of abuse.

Sources: Review of CIR, the licensee's internal investigation documents, "Zero Tolerance of Resident Abuse and Unlawful Conduct" Policy, and interview with staff. [194]