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 sous la Loi de 2007 sur 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 7, 2016	2016_461552_0020	010270-16	Complaint

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

Port Perry Place
15941 Simcoe Street Port Perry ON L9L 1N5

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

MARIA FRANCIS-ALLEN (552)

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): July 27, 28, 29, August 2, 3 & 4th, 2016

Complaint log #010270-16 related to falls and change in condition

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), family and residents

Also observed staff to resident interaction during provision of care, review of clinical health records and policy related to falls

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #005 was reassessed and the plan of care was reviewed and revised when the resident's care needs changed during an identified period.

Resident #005 was admitted to the home on an identified date and had several medical diagnosis including cognitive impairment. Review of the clinical health records indicated resident #005 ambulated independently without the use of any mobility device and was at risk for falls due to poor balance.

Documentation found in the progress notes for an eight day time frame indicated the following:

- On an identified date resident #005 was observed with an increased limp - physiotherapy (PT) referral was completed.
- The following day, resident #005 fell and sustained injuries. The resident's family and physician were notified. Vital signs and neurological checks were taken and recorded. Further documentation on this date also indicated resident #005 had a cough with an elevated temperature.
- No further documentation of a cough was found until two days later when RPN #103 documented resident #005 had a cough and that this information would be reported to the staff on the next shift to monitor.
- The following day at a specific time, RPN #103 conducted and documented results from a physical examination. The MD was notified, medication and diagnostic test ordered as a precautionary measure. The substitute decision maker (SDM) was also notified about the physician orders. Resident 005's temperature remained elevated during the shift.
- The following day, the staff documented resident #005 had a cough but no abnormal sounds were present. The resident's temperature recorded as above range. Later that day documentation from RPN #103 indicated a cough could be heard on two occasions from upper chest area. Oxygen saturation rate and temperature were abnormal.
- The following day, it was documented resident #005 had cough involving upper chest twice this shift. Vital signs taken and recorded.
- The following day, vital signs were taken and recorded. There was no mention of chest assessment being done or of resident #005 having a cough.
- The following day at a specific time, RN #112 documented being called by RN #113 to assess resident #005 who was not responding to verbal or painful stimuli and vital sign reading were abnormal. The MD was notified and RN #113 indicated orders have been

received to send the resident to hospital. The resident was handed over to the paramedics several minutes later.
- On the same day (late entry after resident #005 was sent to the hospital) - RN #113 documented resident #005's vital sign, that the resident did not have a cough and felt warm to touch
- On the same day - RN #112 received an update from the hospital about resident #005's condition.
- On the same day (late entry after resident #005 was sent to the hospital) - RN #113 documented she was asked to assess resident #005 at a specific time due to change in the resident's condition. Another nurse was called to complete further assessment and 911 was called.
- On the same day (late entry after resident #005 was sent to the hospital) - documentation by RN #113 indicated resident #005 was not allowing staff to conduct a physical examination. Staff conducted a partial examination and observed some congestion but no other abnormalities.
- On the same day - hospital called the home to provide further update on resident #005's condition.
There is no documented evidence to support the diagnostic test ordered had occurred. Review of the care plan (for that period) did not include the change in resident #005's care needs between a specific time frame.
During an interview with the Director of Care on July 29, 2016 she confirmed the diagnostic test ordered had not been done and the care plan did not reflect the change in resident #005's condition. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 8th day of September, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARIA FRANCIS-ALLEN (552)
Inspection No. / No de l'inspection :	2016_461552_0020
Log No. / Registre no:	010270-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 7, 2016
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
LTC Home / Foyer de SLD :	Port Perry Place 15941 Simcoe Street, Port Perry, ON, L9L-1N5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marva Griffiths

To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall ensure that every resident exhibiting signs and symptoms of possible respiratory infection are re-assessed and the plan of care reviewed and revised when the resident's care needs have changed.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #005 was reassessed and the plan of care was reviewed and revised when the resident's care needs changed during an identified period.

Resident #005 was admitted to the home on an identified date and had several medical diagnosis including cognitive impairment. Review of the clinical health records indicated resident #005 ambulated independently without the use of any mobility device and was at risk for falls due to poor balance.

Documentation found in the progress notes for an eight day period indicated the following:
- On an identified date resident #005 was observed with an increased limp - physiotherapy (PT) referral completed.
- The following day, resident #005 fell and sustained injuries. The resident's family and physician were notified. Vital signs and neurological checks were taken and recorded. Further documentation on this date also indicated resident #005 had a cough and temperature.

- No further documentation of a cough was found until two days later when RPN #103 documented resident #005 had a cough and that this information would be reported to the staff on the next shift to monitor.
- The following day, RPN #103 conducted and documented results from a physical examination. The MD was notified, medication and a diagnostic test was ordered as a precautionary measure. The substitute decision maker (SDM) was also notified about the physician orders. Resident #005's temperature was documented as elevated during the shift.
- The following day, the staff documented resident #005 had a cough but no abnormal sounds were present. Temperature recorded as being above range. Later that day documentation from RPN #103 indicated a cough could be heard on two occasions from upper chest area. Oxygen saturation rate and temperature was abnormal.
- The following day, it was documented resident #005 had a cough involving the upper chest twice this shift. Vital signs documented including oxygen saturation rate.
- The following day, vital signs are recorded. There was no mention of chest assessment being done or of resident #005 having a cough.
- the following day, RN #112 documented being called by RN #113 to assess resident #005 who was not responding to verbal or painful stimuli and vital sign results were abnormal. The MD was notified and RN #113 indicated orders have been received to send resident #005 to hospital.The resident was handed over to the paramedics several minutes later.
- On that same day (late entry after resident #005 was sent to the hospital) - RN #113 documented resident #005 vital signs including oxygen saturation rate - no cough noted. Resident felt warm to touch
- On that same day - RN #112 received a call from hospital regarding resident #005's condition.
- On that same day (late entry after the resident was sent to the hospital) - RN #113 documented being asked to assess resident #005 at a specific time due to change in condition. Another nurse was called to complete further assessment and assistance and 911 was called.
-On that same day (late entry after resident #005 was sent to the hospital) - documentation by RN #113 indicated the resident was not allowing staff to conduct a physical examination. Staff conducted a partial examination and observed some congestion but no other abnormalities.
- On that same day - hospital called the home to provide further update on resident #005's condition.

There is no documented evidence to support the diagnostic test ordered had

occurred. Review of the care plan (for that period) did not include the change in resident #005 care needs exhibited within a specific time frame.
During an interview with the Director of Care she confirmed the diagnostic test ordered had not been done and the care plan did not reflect the change in resident #005's condition.
(552)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 7th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Maria Francis-Allen

Service Area Office /
Bureau régional de services : Ottawa Service Area Office