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 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**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 4, 2019 | 2018_591623_0020 | 001792-18 | Complaint |

### Licensee/Titulaire de permis

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

SARAH GILLIS (623)

### 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): November 19, 20 and 21, 2018**

**The following intake was inspected:**
**Log #001792-18 - Complaint related to allegations of neglect of care of a resident.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Nurse Consultant for Extendicare Assist (Acting DOC), Registered Nurse(s) (RN), Registered Practical Nurse(s) (RPN), Personal Support Worker(s) (PSW), and families.**

**In addition, the following were reviewed: clinical medical records, the licensee's internal investigation, staff education records and related policies.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Reporting and Complaints**

**During the course of this inspection, Non-Compliances were issued.**
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that assessments are integrated, consistent with and complement each other.

Related to Log #001792-18

A complaint was received by the Director on a specified date, indicating that the complainant alleged resident #001 had been neglected when the SDM voiced concerns to the nursing staff about a change in condition for resident #001, and requested that the resident be tested for a specified infection. The complainant indicated that resident #001 continued to decline over a period of one month and staff did not respond to the SDM's repeated request for investigation into the cause. On a specified date, resident #001 experienced an unresponsive episode and was transferred to the hospital for assessment. Resident #001 was diagnosed in hospital with a specified infection and treatment was ordered.

Review of the physician orders for a specified period of time, indicated that on a specified date, the physician ordered that a specified test be completed for resident #001 at the request of the SDM. This order was documented in the physician orders section of the paper chart and was not entered into the progress notes by RPN #103. Ten days later an order was obtained for specified medication to be administered routinely for complaints of pain. Five days later, resident #001 was transferred to the hospital when they became unresponsive. 19 days after the initial order was obtained to complete a specified test, the physician wrote orders to discontinue the request for the specified test since the test was performed when the resident was in the hospital.

Review of the diagnostic testing for resident #001 was completed by Inspector #623, there were no records to indicate that the specified test that was ordered on a specified date, had been obtained by staff. Records revealed a report for a specified test that was completed on a specified date at the hospital, which identified resident #001 was experiencing an infection, specified tests identified the specified bacteria.

Review of the progress notes for resident #001 for a specified period of time identified ten entries in the progress notes what described resident #001 as being unwell or not their usual self, occasional complaints of pain in a specified area, refusal to eat or get out of bed. There were two entries indicating concerns brought forwards by the SDM indicating that resident #001 was not their usual self, requesting that the physician be notified and inquiring if a specified test had been completed as ordered. On a specified date when RPN #107 discovered resident #001 to be lethargic and not responsive. RPN #107 documented that the SDM arrived at the home when resident #001 was being assessed, and insisted the resident be transferred to the hospital for further assessment. The RPN indicated that the SDM believed this was a result of resident #001 having an undiagnosed infection. Resident #001 was transferred to hospital as requested by the SDM.

On a specific date, the Corporate Consultant in the Acting DOC role, documented that a meeting was held at the SDM's request. The SDM expressed concerns regarding a specific test that was ordered and not completed. The Acting DOC and the Executive Director apologized and discussed methods for improvement. The SDM identified they did not want a similar incident to happen to another resident. The Acting DOC documented that they would follow up and notify the SDM of the final outcome of the improvement plan that is implemented.

On a specific date, RPN #107 documented that resident was transferred to another Long-term Care facility.

On a specific date and time, during an interview with Inspector #623, RN #102 indicated that they recalled the resident had recurrent infections and was often on specified medication for treatment. The RN indicated that resident #001 had impaired cognition and as per the "Care Path" for symptoms of a specific infection, staff are to follow the flow chart. RN #102 indicated that staff try to educate families regarding treating the symptoms rather than obtaining random testing. RN #102 indicated that the specified test is only completed with an order from the physician or nurse practitioner. The nursing staff are not permitted to complete this test without an order. RN #102 indicated that when an

order is received to obtain a specified test for a resident, the registered nurse or registered practical nurse is responsible for processing the order, which includes creating a lab slip, writing a progress note and adding the need for the test to the staff communication page in Point Click Care (PCC) or document it in the calendar at the nursing station. This information should be passed on for each shift until the specified test is completed. The RN indicated that when the order is first and second checked on the order sheet, there is a place to indicate that a lab requisition has been completed, this should be checked off. For resident #001, upon review of the order written on a specific date, this did not appear to be completed. RN #102 indicated that if there was an order for resident #001 to have the specified test, on a specified date, then the test should have been completed within a few days of obtaining the order.

On a specified date and time, during an interview with Inspector #623, RPN #105 indicated that when a doctor's order is received to obtain a specified test, staff would pass this on verbally to the night nurse so that they could arrange for the test to be completed in the morning. RPN #105 indicated that if the specified test had not been completed in 1-2 days, then they would contact the physician for an order to arrange for the test to be completed using a different method. RPN#105 indicated that they would document in the progress notes all attempts to complete the specified testing that were unsuccessful, as well as document once the specified testing had been completed. The RPN indicated that when a resident has an order for a specified test, a requisition is made out and the information is written in the calendar book for the unit and moved forward each day until it is completed. RPN #105 reviewed the book with Inspector #623, for a specified time period and there was no documentation to indicate that resident #001 required a specified test. RPN #105 indicated that when a physician's order is second checked by the nurse, this is the step when the nurse ensures that the order was processed properly. RPN #105 signed the 2nd check of the order for resident #001 on a specified date, as evidenced by the signature. RPN #105 could not recall checking this specifiic order. RPN #105 confirmed that the order for resident #001 does not indicate that a lab slip was completed for the order to complete a specified test for resident #001. RPN #105 confirms that this should have been checked off if it had been completed.

On a specific date and time, during an interview with Inspector #623, the Director of Care (DOC) indicated that during a specified time period when the concerns were brought forwards by the SDM for resident #001, there was an interim DOC appointed by the management company, to cover the position of DOC, this was a Corporate Nursing Consultant. The DOC indicated that the expectation of the licensee is that when a physician orders a specific test, the order should indicated the method that the test is to

be completed. The order that was written on a specified date, for resident #001 does not identify how the test is to be completed. The DOC indicated that when a nurse receives an order, this is expected to be documented in Point Click Care (PCC) so that the information is auto populated into the 24 hour report as a means of communication. The physician order that was written on a specified date, was not documented in the progress notes for resident #001, therefore it could not be verified whether it had been communicated to staff. The DOC indicated that when an order is received to obtain a specified test, it is the expectation that this test would be completed as soon as possible, regardless of whether the resident is displaying symptoms or not. If the resident was uncooperative or unable to assist with completing the testing, there should be documentation to indicate that an effort was made to complete the testing and indicate what the reason was for not completing the order. The DOC indicated that not not completing a specified test that was ordered 15 days prior was unacceptable, especially considering that there was no documentation to indicate why it was not completed and to support that any effort was made to attempt to complete the testing.

On a specific date and time, during a telephone interview with Inspector #623, the Nurse Consultant for the management copmany who was in the role of Acting DOC for the home during a specific identified time, indicated the following; The Acting DOC indicated that they first became aware of the concerns brought forwards by the SDM for resident #001 on a specific identified date. The Acting DOC indicated that they did not look into the order for the specified testing and why it was not completed. The Acting DOC indicated being unsure if the specified testing was actually ordered, they did not review the progress notes or physician orders as part of their investigation. The Acting DOC indicated that the expectation would be that if an order is received to obtain a specified test, it would be completed the following morning after the order is received. This information should have been communicated from shift to shift until the testing was completed. The Acting DOC indicated that if nursing staff were unable to complete the specified testing, the physician should have been notified so that an order could be obtained for alternative method of testing. Staff should not have waited more than four or five days before contacting the physician if unable to complete the specified testing.

Repeated concerns to the nursing staff from the SDM for resident #001, were not communicated with members of the health care team. There was no indication that there was collaboration with the SDM or from shift to shift, when the SDM identified concerns to the nursing staff about resident #001 regarding changes in condition. When an order was obtained to complete specific testing, there was no indication this was communicated between the shifts, and when the testing was not completed, there was

no indication that nursing staff communicated with the prescriber, to seek alternative ways to obtain the testing. 15 days later a physicians order to obtain a specific identified test, had not been completed, resident #001 was discovered unresponsive and required transfer to the hospital for further assessment.

The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that assessments are integrated, consistent with and complement each other. [s. 6. (4) (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 by ensuring that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that assessments are integrated, consistent with and complement each other, to be implemented voluntarily.***

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**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 has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director?
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Related to Log #001792-18

A written complaint was submitted to the licensee on a specified date, by the SDM for resident #001. The written complaint indicated that the SDM was requesting a meeting to discuss the care needs for resident #001. The resident was discovered unresponsive that day and required to be transferred to the hospital for assessment. An initial meeting was held on a specified date, with the SDM, other family members, the Executive Director for the home at the time and the Acting DOC. The notes from the meeting indicated that the SDM was frustrated with the nursing staff and the response time to address concerns that were brought forward by the SDM. The notes indicated that the SDM had requested a specific test be completed a month prior, and this was not done. The notes also indicated that the SDM felt that their concerns were being passed off to the next shift and no one was ever addressing them.

On a specific date and time, during an interview with Inspector #623, the SDM indicated that they submitted a written complaint to the Director of Care on a specified date, indicating that they had concerns with the care of resident #001 related to the delayed testing and treatment for a specified infection. On a specified date resident #001 was discovered unresponsive and was transferred to the hospital for assessment. The SDM indicated that the home did not follow through on a physician's order to obtain a specified test, they ignored the SDM's concerns regarding the change in resident #001's condition would always say that they couldn't complete the specified testing. The SDM indicated it was over a month from the time the SDM first brought forward concerns to when the resident was sent to hospital. It wasn't until the resident became unresponsive, they were transferred the hospital and diagnosed with a specified infection, when they finally received treatment. The SDM indicated that the nursing staff refused to request a physician order to complete the test using an alternative method. Resident #001 had a known history of specific identified infections and sepsis. The SDM indicated that

previously they had left messages on the answering machines for the Charge RN, but would never receive a response. Their concerns were then submitted in writing so that someone would be required to respond. A meeting was scheduled for a specified date, with the ED and Acting DOC. The SDM indicated that during the meeting, management indicated to the SDM, that they had "let the resident and the family down" and that they would complete an investigation and let the SDM know the outcome. The SDM was unaware of the outcome of the homes investigation.

On a specific date and time, during an interview with Inspector #623, the Nurse Consultant who was in the role of Acting Director of Care (DOC) for the home during a specific identified time, indicated the following:
The Acting DOC indicated to Inspector #623, that they received a written compliant from resident #001's SDM on a specified date, when they arrived at work, the letter was dated two days prior. The Acting DOC indicated that they immediately contacted the SDM to set up a meeting to discuss the concerns, this meeting took place on a specified date. The Acting DOC indicated that the written complaint was an allegation of neglect of care. The Acting DOC indicated that at the time the complaint was received, they did not consider the complaint an allegation of neglect of care. The Acting DOC indicated that this complaint was not reported to the Director as a Critical Incident for alleged neglect. The Acting DOC indicated that the expectation of the licensee is that any alleged, suspected or witnessed abuse or neglect of a resident, will be immediately reported to the Director.

The licensee failed to ensure that the person who had reasonable grounds to suspect that neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. When a specific test that was ordered for resident #001 was not obtained, which resulted in the deterioration of resident #001's condition, requiring transfer to hospital. [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 by ensuring that the person who has reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.***
***1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.***
***2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

**Specifically failed to comply with the following:**

**s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:**
**3. A response shall be made to the person who made the complaint, indicating,**
**i. what the licensee has done to resolve the complaint, or**
**ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).**

**s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,**
**(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).**
**(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).**
**(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).**
**(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).**
**(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).**
**(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident of operation of the home, a response is made to the person who made the complaint, indicating: what the licensee has done to resolve the complaint or that the licensee believes the complaint to be unfounded and the reasons for the belief.

Related to Log #001792-18

A complaint was received by the Director on a specified date, indicating that the complainant alleged resident #001 had been neglected when the SDM voiced concerns to the nursing staff about a change in condition for resident #001, and requested that the resident have a specified test. The resident continued to decline over a period of one month and staff did not respond to the SDM's request for investigation into the cause. On a specified date, resident #001 experienced change in condition which required transferred to the hospital for assessment. It was then discovered that resident #001 had a specific infection and treatment was ordered.

On a specific date and time, during an interview with Inspector #623, resident #001's SDM indicated that they submitted a written complaint on a specified date indicating that they had concerns with the care of resident #001 related to the delayed testing and treatment for a specific identified infection. They indicated that previously they had left messages on answering machines for the Charge RN, but never received a response, so they left the request in writing so that someone would respond. The SDM indicated a meeting was finally scheduled for a specified date, with the previous ED and Acting DOC. The SDM indicated that they were unaware of the outcome of the homes investigation. The SDM indicated that following the initial meeting on a specified date, there was no further information provided to the SDM regarding the outcome of the licensee's investigation into their complaints.

On a specified date and time, during an interview with Inspector #623, the Executive Director (ED) indicated that they were not in the position of ED during the specified time period. During the same specified time, there was a management company appointed Nursing Consultant in the role of Acting Director of Care. The ED indicated that the complaint log records identified a complaint investigation was initiated on a specified date, by the Acting DOC, to address the written concerns brought forward by the SDM of resident #001. The ED provided Inspector #623 with the written record of the complaint

received from resident #001's SDM. The written records indicated that the allegation was founded, but there is no written record of the actions taken. The ED indicated that some records appear to be missing. The ED indicated that after consulting with the former Acting DOC, there was no further information to add to the licensee's internal complaint investigation records. The former Acting DOC indicated to the ED, they did not recall submitting the complaint to the Director and did not recall following up with the complainant as per policy.

The licensee failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident of operation of the home, a response is made to the person who made the complaint, indicating: what the licensee has done to resolve the complaint or that the licensee believes the complaint to be unfounded and the reasons for the belief. [s. 101. (1) 3.]

2. The licensee has failed to ensure that a documented record is kept in the home that includes:
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

Related to Log #001792-18

A written complaint was submitted to the licensee on a specified date, by the SDM for resident #001.

A review of the licensee's internal complaint log by Inspector #623, identified that the complaint was received by the Acting Director of Care (DOC) on a specified date. The investigation summary indicated that on the date the complaint was received, a call was placed to the SDM to schedule a meeting that was to take place two days later. The Investigation Observation Form identified that a meeting took place on a specified date. The notes hand written by the Acting DOC indicate that the SDM advised the licensee that they were disappointed in the care that was provided to resident #001, and the lack of follow-up by the staff when a concern was brought forward by the SDM. A note on a specified date, indicated that resident #001 would be transferred to another long-term care facility. The observation form notes indicate that resident #001 had been discharged

on a specified date. The licensee's investigation package also contained a hand written document (author not identified) that appeared to be minutes from the meeting with the SDM. The notes indicated the identified concerns brought forward by the SDM related to their frustration with staff, the request two months prior for a specified test to be completed for resident #001, which was not followed through and the lack of ownership by nursing of the concerns brought forward by the SDM. The notes indicated that the Acting DOC would follow up with the nursing staff. There was no further documentation in the records to indicate the type of action taken to resolve the complaint, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant.

On a specified date and time, during an interview with Inspector #623, the Executive Director (ED) indicated that they were not in the position of ED during the specified time period. During the same specified time, there was a management company appointed Nursing Consultant in the role of Acting Director of Care. The ED indicated that the complaint log records identified a complaint investigation was initiated on a specified date, by the Acting DOC, to address the written concerns brought forward by the SDM of resident #001. The ED provided Inspector #623 with the written record of the complaint received from resident #001's SDM. The written records indicated that the allegation was founded, but there is no written record of the actions taken. The ED indicated that some records appear to be missing. The ED indicated that after consulting with the former Acting DOC, there was no further information to add to the licensee's internal complaint investigation records.

The licensee failed to ensure that a documented record is kept in the home that included; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required. The final resolution, if any. Every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant. [s. 101. (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 by ensuring that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident of operation of the home, a response is made to the person who made the complaint, indicating: what the licensee has done to resolve the complaint or that the licensee believes the complaint to be unfounded and the reasons for the belief.***

***Also by ensuring for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident of operation of the home, that a documented record is kept in the home that includes:***
***(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required***
***(d) the final resolution, if any***
***(e) every date on which any response was provided to the complainant and a description of the response, and***
***(f) any response made by the complainant, to be implemented voluntarily.***

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**Issued on this 10th day of January, 2019**

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

**Original report signed by the inspector.**