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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 23, 2019	2019_670571_0007	009401-18, 010745-18, 019741-18, 019939-18, 023303-18, 026150-18, 028580-18, 029654-18, 033013-18, 004121-19	Complaint

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

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

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

PATRICIA MATA (571)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 28, 29, April 1-5, 9-12, 15-17, 23-26, 2019.

The following complaints were inspected:
Log #029654-18 related to palliative care, log #004121-19 related to falls, log #026150-18 related to personal care, log #019741-18 related to personal care, log #019939-18 related to personal care, 028580-18 related to palliative and personal care, 033013-18 related to falls and personal care and 009401-18 related to falls.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), former DOC, Environmental Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Worker (PSW), Physiotherapist Assistants (PA), Nursing Clerk, Office Manager, Physician, Housekeeping Aides, residents and Power of Attorney's for residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Personal Support Services
Responsive Behaviours

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)**

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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that assessments and reassessments of resident #002, after their fall, were documented as per the licensee's Fall Prevention and Management Program.

Related to log #004121-19:

Resident #002 fell on a specified date and sustained an identified injury.

Under section 48 of the Ontario Regulation 79/10, (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

A review of the licensee's "Falls Prevention and Management Program" RC-15-01-01 last updated on February 2017 indicates under Procedures, for 72 hours, post-fall: 1. Assess the following at each shift: a. Pain; b. Bruising; c. Change in functional status; d. Change in cognitive status; and e. Changes in range of motion. 2. Communicate resident status at end of each shift. Communicate new falls, fall injuries, flagged residents and precautionary measures at daily clinical meeting. 4. Document the fall and results of all assessments and actions taken during the 72-hours post-fall follow-up.

After review of resident #002's progress notes and 24 hour nursing communication report for a specified time period, no evidence could be found that a specified assessment was documented, as per the licensee's policy #RC-15-01-01, on four out of nine shifts in the identified 72 hour post falls period. Furthermore, on the "24 hour Nursing Communication Report" notation of specified assessment could only be found on three shifts out of nine shifts over the 72 hour post falls period.

In an interview with Inspector #571, RPN #110 indicated they provided a specific assessment of resident #002's injuries on a specified date and time one day after the injury occurred.

In an interview with Inspector #571, RPN #119 indicated that they worked on a specified date and time two days after the injury occurred. The RPN indicated that they were taken aback when they saw the resident's injury. RPN #119 did not inform the Physician as they thought that the Physician must already be aware. RPN #119 did not know that the resident's injury had worsened. RPN #119 indicated that when they started their shift, they got a verbal report, assessed the resident and read the progress notes for the

previous 24 hours.

In an interview with Inspector #571, Physician #120 indicated that they were notified of the original fall on a specified date and gave the nurse telephone orders. At that time they were told that the resident had specified injuries. Physician #120 was then called on a specified date two days later and informed that a family member was concerned about resident #002's injury. The nurse reported to Physician #120 that they had educated the family that the injury was normal, that orders had been given by the Physician and the resident was being monitored. Physician #120 indicated that the nurse had reported that the injury had worsened somewhat. Physician #120 indicated that the nurse was not concerned about the injury so Physician #120 gave the nurse specific instructions. The resident's Substitute Decision Maker called the Physician the next day on a specified date and sent the Physician a picture of the resident's injuries that been taken the previous day by the other family member. When the Physician saw the picture, they informed the SDM that the resident needed further intervention at a hospital. Physician #120 indicated that if the nurse that had called the Physician on the specified date the previous day had been concerned, than they would have come in to the home to see the resident that night or advised further intervention at a hospital. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 received end-of-life care that

meets their needs.

Regarding Complaint log #029654-18:

A complaint was received through the Infoline on a specified date regarding poor personal and end-of-life care that had been provided to resident #001.

A review of the physician orders indicated that specified measures/orders were put into place on a specified date.

A review of resident #001's electronic medication administration record and progress notes over a specified period indicated that medications to alleviate specific symptoms were not fully utilized.

In a telephone interview, the Substitute Decision Maker (SDM) for resident #001 indicated that on a specified date the resident was displaying specified symptom. The SDM rang the call bell but it was not answered so they went to the desk and informed RPN #143 that resident #001 needed medication for specified symptoms. RPN #143 told the SDM that they would be right down. Twenty minutes later, RPN #143 still had not gone to the room. The SDM indicated that they went to the desk three more times to ask for help. RPN #143 informed the SDM that they were very busy. The SDM requested that the RN be called; RPN #143 indicated that the RN was very busy. The SDM became distraught. RN #125 arrived on the unit to speak to the SDM afterward. The SDM indicated that RN #125 did not want to give resident #001 medication as it would slow the resident's respirations down. The SDM informed RN #125 that it did not matter if the resident's respirations were slowed as they did not want resident #001 to suffer. The SDM indicated that they had to leave the home at a specified time on that date but were worried because resident #001 continued to display specified symptoms. PSW #133 indicated that they would sit with resident #001 and get the nurse to give the resident more medication.

Inspector #571 interviewed PSW #133. They indicated that they were asked by RN #125 to sit with resident #001 at their bedside on a specified date for a specified length of time as the resident was displaying specified symptoms. PSW #133 informed RN #125 and RPN #143 of specific symptoms displayed by the resident during that time and requested medication be given to the resident to alleviate symptoms. PSW #133 indicated that during the specified length of time that they were with the resident, RN #125 and RPN #143 did not provide medication and only replied they were looking into it when PSW

#133 inquired. PSW #133 indicated that they tried to comfort resident #001. PSW #133 witnessed RN #125 tell the SDM that the staff were doing their best and indicated that the end of life was not always pleasant.

Inspector #571 interviewed RN #125 via telephone on a specified date. RN #125 indicated that they could not recall resident #001 or the events that occurred on two specified dates.

Inspector #571 interviewed RPN #143 on a specified date. RPN #143 indicated that they did not remember the details of the care they provided to resident #001 a specified date, only what they documented. RPN #143 indicated that the SDM told them the resident had specified symptoms and that they gave the resident medication. RPN #143 indicated that RN #125 also spoke with the family.

Inspector #571 interviewed the former DOC via telephone. They indicated that they did investigate a complaint received from the SDM of resident #001 on a specified date. The former DOC indicated that the plan of care for resident #001's end-of-life care was not developed with input from the resident or the SDM nor with collaboration with the interdisciplinary team.

A review of a "Complaint Investigation Form" completed by the former DOC for a specified date, indicated that the SDM complained that the resident did not get adequate symptom relief and two other identified care issues. The DOC informed the SDM that there would be Palliative Care education for the staff and that they would speak to both staff involved. The DOC indicated on the complaint form that the complaint was founded.

The licensee has failed to ensure that resident #001 received end-of-life care when required in a manner that met their needs [s. 42.]

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 with ensuring that each resident receives end-of-life care when required in a manner that meets their needs, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to develop and implement strategies to respond to resident #021's responsive behaviour.

Regarding Log 019741-18:

A complaint was submitted to the Director on a specified date regarding resident #021's care needs not being met.

Inspector #571 reviewed resident #021's progress notes for a specified time period

A review of the care plan in place at the time of the inspection indicated the resident had identified responsive behaviours. Triggers were identified. Specified interventions were in place but did not provide clear strategies for staff to manage the resident's identified responsive behaviour.

In an interview with Inspector #571, RPN #110 indicated there was no longer a Behavioural Assessment Tool in use for resident #021 as the resident had not had many complaints lately. RPN #110 indicated that the resident had identified responsive behaviours.

In an interview with Inspector #571, PSW #131 indicated specific information about resident #021's identified responsive behaviour on specified dates and times. PSW #131 indicated that the time spent trying to manage resident #021's responsive behaviour limited the time the staff could spend providing care to other residents. The PSW stated that there were no strategies in place to help staff manage resident #021's responsive behaviours.

In an interview with Inspector #571, the Executive Director (ED) indicted that they had tried interventions related to resident #021's responsive behaviour in the past.

Resident #021 continued to have identified responsive behaviours. Strategies to respond to this behaviour were not identified and implemented. [s. 53. (4) (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 with ensuring that strategies are developed and implemented to respond to resident #021's responsive behaviours , to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use safe transferring and positioning device or techniques when assisting residents.

Regarding log #023303-18:

A complaint was submitted to the Director on a specified date regarding safe positioning devices or techniques.

Resident #018's progress notes for a specified time period were reviewed by Inspector #571. On a specified date, the RPN documented that a specific intervention should have been in place. As a result of the intervention not being in place, an incident occurred that had a potential for injury but did not cause injury.

Inspector #571 reviewed resident #018's care plan that was in place at the time of the incident. The care plan indicated that a specific intervention was to be in place.

In an interview with Inspector #571, physiotherapist assistant #142 indicated that they were not involved in the incident but were aware that it had occurred. [s. 36.]

Issued on this 18th day of June, 2019

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

Original report signed by the inspector.