Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Dec 5, 2019	2019_716554_0006	015677-19, 020408-19, 020457-19, 020703-19, 021055-19, 021268-19	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

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

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

KELLY BURNS (554)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 16, 17, 18, 21, 22, 23, and October 31; November 01, and November 05-07, 2019.

The following intakes were inspected, #015677-19, #020408-19, #020457-19, #020703-19, #021055-19 and #021268-19.

Summary of Intakes inspected:
- Log #015677-19, #020408-19, #020457-19 and #020703-19 - are related to incidents that caused injury to a resident for which the resident was transferred to hospital and resulted in a significant change in the resident's health condition.
- Log #021055-19 (CIR #2629-000031-19) and #021268-19 (CIR #2629-000032-19) - are related to written complaints regarding alleged neglect of a resident.

Log #021055-19 (CIR #2629-000031-19) and Log #021268-19 (CIR #2629-000032-19), are related to resident #007 and are associated with complaint log #018471-19 and log #020519-19. Non-Compliance related to these intake logs, specific to resident #007 and all intakes will be identified in inspection report #2019_716554_0007 which was conducted currently with this inspection.

Non-Compliance related to Log #015677-19 was identified during this inspection pursuant to LTCHA, 2007, s. 6, specifically s. 6 (1) (c), s. 6 (7) and s. 6 (11) (b) and the non-compliance will be issued under Inspection Report #2019_716554_0007, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Regional Director for Extendicare Assist, Clinical Coordinator (CC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Housekeeper (HSK), the Physiotherapist (PT), families and residents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **1 WN(s)**
- **1 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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee failed to inform the Director no later than one business day after the occurrence of the incident, specifically an incident that caused an injury to a resident for which the resident was taken to the hospital and which resulted in a significant change in the resident's health condition.

Related to Log #020457-19:

A CIR was submitted to the Director on an identified date, regarding a fall that caused an injury to resident #002 for which the resident was taken to the hospital and which resulted in a significant change in the resident's health condition.

The progress notes, for resident #002 were reviewed by Inspector #554 and identified the following:

- On an identified date, staff witnessed resident #002 sliding from a chair onto the floor. Resident #002 complained of discomfort following the incident.

- The next day, progress notes indicated that resident #002 complained of discomfort to identified areas, resident #002 was unable to stand from a sitting position without voicing discomfort. Resident #002 was administered prescribed medications for comfort. The physician was notified of the incident and subsequent injury, orders were received to transfer to hospital for assessment. At an identified hour, resident #002's SDM was notified of the transfer to hospital. At an identified hour RN #100 was informed by resident's SDM that resident had been diagnosed with an identified injury. Resident #002 was discharged from hospital and readmitted to the long-term care home the same day. Resident was assessed upon readmission to the long-term care home to need assistance of two-staff for transfers and required a mobility aid for mobility. Referrals were sent to the PT and an Occupational Therapist.

The Clinical Coordinator-RN #100 (CC-RN) indicated to Inspector #554 during an interview that resident #002 had a significant change in health condition following the incident. RN #100 indicated resident #002 required increased assistance from staff for transfers, toileting and required a mobility aid following the incident.

The DOC indicated to Inspector #554 during an interview being aware of the required timelines for the submission of the CIR to the Director. The DOC indicated the CIR

specific to resident #002's incident on an identified date and had not yet been submitted.

The licensee has failed to inform the Director no later than one business day after the occurrence of an incident, specifically an incident that caused an injury to resident #002 for which the resident was taken to the hospital and which resulted in a significant change in the resident's health condition.

2. The licensee failed to inform the Director no later than three business day after the occurrence of the incident, specifically a fall that caused an injury to a resident for which the resident was taken to the hospital and resulted in a significant change in the resident's health condition.

Related to Log #020408-19:

A CIR was submitted to the Director on an identified date, regarding an incident that caused an injury to resident #006 for which the resident was taken to the hospital and which resulted in a significant change in the resident's health condition.

The progress notes, for resident #006 were reviewed by Inspector #554 and identified the following:

- On an identified date a progress note indicated that resident #006 was found on the floor. Resident #006 had self-transferred and walked to the washroom without the assistance of staff or a mobility aid. Resident #006 complained of discomfort and was assessed to have injury. Resident #006 was transferred to hospital for further assessment. Resident #006 was assessed at the hospital, discharge and was readmitted back to the long-term care home on an identified date. Physician orders were received to hold an identified medication. Identified assessments were initiated upon return to the long-term care home.

- Progress notes during a identified period indicated that resident remained on bedrest following readmission to the long-term care home. Resident #006 had identified injuries, had increased discomfort, was assessed to require an identified lift for transfers and required three staff to assist in bed mobility. Resident was discharged from the restorative nursing program due to resident's inability to participate in dressing, grooming, toileting and transferring. Resident #006 required assessments for comfort and mobility by registered nursing staff and the PT.

RN #101 and CC-RN #100 indicated to Inspector #554 during an interview that resident #006 had a significant change in condition following the incident. RN #101 indicated that the resident remained on bedrest following readmission to the long-term care home. Both RNs indicated resident #006 required total assistance from staff for all activities of daily living including dressing, transfers, toileting and bed mobility following the incident.

The DOC indicated to Inspector #554 during an interview being aware of the required timelines for the submission of the CIR to the Director. The DOC indicated the CIR specific to resident #006's incident on the identified date had been submitted late.

The licensee has failed to inform the Director no later than three business day after the occurrence of an incident, specifically an incident that caused an injury to resident #006 for which the resident was taken to the hospital and which resulted in a significant change in the resident's health condition.

Related to Log #020703-19:

A CIR was submitted to the Director on an identified date, regarding an incident that caused an injury to resident #007 for which the resident was taken to the hospital and which resulted in a significant change in the resident's health condition.

RPN #102 and the CC-RN #100 indicated to Inspector #554 during an interview that prior to the incident on the identified date, resident #007 was able to weight bear and to transfer with the assistance of one-two staff.

The progress notes, for resident #007 were reviewed by Inspector #554 and identified the following:

- On an identified date resident #007 was injured while operating an identified mobility aid. Resident #007 attempted to turn the mobility aid around, ran into an object and struck the object. Resident #007 complained of discomfort to an identified area. The resident's SDM was notified and the SDM requested that diagnostics be ordered.

- The next day resident #007 was discharged from the restorative nursing program. RPN #102's documentation indicated that resident was diagnosed with a specific injury, was assessed to require an identified lift and was unable to weight bear.

- The next day resident #007 continued to complain of discomfort and medications were

administered with effect. A physiotherapy referral was initiated, resident's physician reviewed the identified diagnostic results, consulted with an surgeon and ordered further diagnostic testing to rule out further injuries.

- On an identified date resident #007 was transferred to the hospital, diagnosed with injury which required treatment.

During an interview RPN #102 and RN-CC#100 indicated that resident #007 had a significant change in health condition following the incident on the identified date. Both registered nursing staff indicated that resident #007 was unable to weight bear and required the use of an identified lift due to the injury.

The DOC and the Administrator indicated to Inspector #554 during an interview being aware of the required timelines for the submission of the CIR to the Director. The DOC indicated being late in submitting the CIR specific to the incident which involved resident #007 sustaining injury.

The licensee failed to inform the Director no later than three business day after the occurrence of the incident, specifically an incident that caused an injury to resident #007 for which the resident was taken to the hospital and which resulted in a significant change in the resident's health condition.

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 ensure that the Director is informed of incidents that cause an injury to a resident for which the resident is taken to the hospital and which results in a significant change in the resident's health condition, to be implemented voluntarily.

Issued on this 5th day of December, 2019

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

Original report signed by the inspector.