Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 20, 2020	2019_716554_0007 (A1)	006802-19, 018471-19, 020465-19, 020469-19, 020519-19, 020603-19, 020621-19	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

Amended by JACK SHI (760) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

To extend the compliance date of the order at the licensee's request.

Issued on this 20th day of February, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

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

Amended by JACK SHI (760) - (A1)

Amended 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): October 16, 17, 18, 21, 22, 23, and October 31; November 01, and November 05-07, 2019.

The following intakes were inspected, log #006802-19, #018471-19, #020465-19, #020469-19, #020519-19, #020603-19 and #020621-19.

Summary of the Intakes:

All intakes logs inspected were related to alleged neglect of a resident, specifically care or services not provided to identified residents.

Non-Compliance pursuant to LTCHA, 2007, s. 6, specifically s. 6 (1) (c), s. 6 (7) and s. 6 (11) (b) were identified in inspection report #2019_716554_0006 related to Log #015677-19. The non-compliance identified will be captured in this inspection report, both inspections were conducted concurrently.

Non-Compliance related to Log #021055-19 and Log #021268-19 identified in inspection report #2019_716554_0006 will be identified in this inspection report as the alleged neglect relates to complaint log #018471-19 and log #020519-19, both are related to the same resident.

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:

Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

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

- **10 WN(s)**
- **7 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee failed to ensure that resident #007 was free from neglect by the licensee or staff in the home.

Pursuant to O. Reg. 79/10, s. 5, for the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a

pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A complaint was received by the Ministry of Long-Term Care regarding the care and services provided to resident #007 by the licensee and the staff.

The complainant indicated to Inspector #554 that the resident had a fall, sustained injury, was transferred to hospital and required treatment. Resident #007 returned to the long-term care home and was not assessed for a number of weeks. The complainant indicated that the lack of assessment of resident #007 was considered neglect of care.

The plan of care, including progress notes, skin assessments, physician orders, electronic medication administration records (eMAR) and electronic treatment administration records (eTAR) for resident #007 was reviewed by Inspector #554.

The progress notes confirmed that the resident had fallen, sustained an injury and was sent to the hospital for treatment.The resident returned to the home and had a prescribed treatment.

The plan of care, including progress notes, skin assessments, physician orders, eMAR and eTAR, was reviewed for identified dates. The review failed to support that resident #007 had received a skin assessment upon return to the long-term care home from the hospital, failed to support that treatments or interventions were implemented to promote healing and failed to support that resident #007 received weekly skin assessments. (Refer to WN #4)

RPN #108 and RN #100 indicated to Inspector #554 during an interview residents returning to the long-term care home from hospital are to have a head to toe assessment. Both registered nursing staff indicated that if altered skin integrity is identified the information would be documented in a skin assessment, a progress note and on the eTAR. RPN #108 and RN #100 indicated that the skin and wound protocols would be implemented, and that the physician would be advised of the skin issue for treatment direction.

RN #100 reviewed the plan of care for resident #007 with Inspector #554 and confirmed that there were no treatments or interventions in place for resident #007 to promote healing. RN #100 indicated that the complainant had raised concerns regarding the treatment.

RN #100 indicated that it was a PSW who had raised concerns, to the registered nursing staff suggesting the resident required treatment. RN #100 indicated that there should have been a physician order obtained when the resident returned to the long-term care home from hospital specific to resident's treatment. RN #100 indicated that following the discovery of the required treatment by a PSW, the resident's physician was contacted for orders.

The health record, for resident #007, indicated that an RPN contacted the resident 's physician to obtain orders for treatment. On the same date treatment was provided to resident #007.

The DOC indicated to Inspector #554 during an interview that physician orders related to the required treatment should have been obtained upon the resident's return to the long-term care home and indicated that resident #007 should have had at a minimum, weekly skin assessments. The DOC indicated being aware that the complainant had raised concerns regarding resident #007's care.

The licensee has failed to ensure that resident #007 was free from neglect by the licensee or staff in the home, specifically regarding an area that was not assessed upon the resident's return to the long-term care home from hospital, was not provided immediate interventions or treatments and did not receive weekly skin assessments.

Additionally, the licensee failed to ensure the written plan of care for resident #007 provided clear direction to staff related to the application and use of recommended assistive aids. (WN #2, VPC); and the licensee failed to ensure resident #007 received toileting assistance from staff to support continence and maintain dignity (WN #5, VPC). [s. 19. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: 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. (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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee failed to ensure that the written plan of care for each resident sets out the planned care for the resident.

A complaint was received by the MLTC regarding the care and services provided to resident #007 by the licensee and the staff.

Resident #007 indicated to Inspector #554 needing assistance of staff for

activities of daily living. Resident #007 indicated the use of assistive aids and the assistance of staff in maintaining their assistive devices.

The complainant indicated to Inspector #554 that the assistive aids for resident #007 was not being consistently maintained.

PSW #106 and RN #100 indicated to Inspector #554 that resident #007 uses assistive aids.

Inspector #554 reviewed the plan of care for resident #007, specifically the written care plan. The written care plan did not identify that resident required assistive aids and how they were to be maintained.

RN #100 reviewed the written plan of care with Inspector #554 and confirmed that the written plan of care did not identify that resident #007 required assistive aids and how they were to be used and maintained. RN #100 indicated that the written plan of care should reflect the care needs of the resident.

The licensee has failed to ensure that the written plan of care for resident #007 sets out the planned care for the resident related to the required use of assistive aids and assistance required. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide care to the resident.

A complaint was received by the MLTC regarding the care and services provided to resident #007 by the licensee and the staff.

The complainant indicated to Inspector #554 that resident #007 required assistive aids to be worn and that staff do not consistently apply the aid correctly.

Resident #007 was observed by Inspector #554 to be wearing an assistive aid.

The plan of care, specifically the written care plan was reviewed by Inspector #554. The plan of care identified that resident #007 was to wear an assistive aid to a specific location.

PSW #106 and RN #100 indicated to Inspector #554 that resident #007 had an assistive aids and only required one at this time.

PSW #106 indicated that staff apply resident #007's assistive aid and indicated the complainant had voiced concerns that the assistive aids were being incorrectly applied. PSW #106 indicated that the assistive aids were being incorrectly applied.

RN #100 indicated being unaware of how resident #007's assistive aids are applied. RN #100 reviewed the plan of care with Inspector #554 and indicated that the plan of care did not provide clear direction as the application of the assistive aid.

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide care to resident #007, specifically the use of and the application of the assistive aids.

B) The MLTC received a complaint regarding the care and services provided to resident #002. The complaint included concerns regarding continence care and management.

The plan of care for resident #002, which included the written care plan, was reviewed by Inspector #554.

The written care plan indicated that resident #002 is at risk for falls and required assistance for transfers and toileting. The written care plan indicated resident's continence level and identified interventions and assistance required.

PSW #103 indicated to Inspector #554 resident's continence level and indicated that the resident was able to request assistance. The PSW indicated that the resident is encouraged to ask for assistance to use the washroom but is known to self-toilet which contributes to resident's safety risk. PSW #103 indicated that resident is not to self-toilet but to be assisted by staff.

RN #100 indicated to Inspector #554 resident #002 is known to toilet self without waiting from assistance of staff. The RN indicated that resident is to be toileted routinely and when requested by the resident. RN #100 reviewed the plan of care with Inspector #554 and indicated that the plan of care, specifically toileting does not provide clear directions as to resident #002's care needs.

The plan of care does not set out clear directions to staff and others who provide

direct care to resident #002 specifically related to toileting and continence care and management.

C) A CIR was submitted to the Director regarding an incident that caused injury to a resident for which the resident was transferred to hospital and which resulted in a significant change in the resident's health condition.

The plan of care for resident #001, including written care plans, was reviewed by Inspector #554. The written care plan identified that resident was at risk for falls and required assistance for transfers and toileting.

A transfer logo observed by Inspector #554 identified that resident #001 required one-staff assistance for transfers.

PSW #109 indicated to Inspector #554 that resident #001 required the assistance of a mobility aid and one-staff for all transfers, RPN #102 indicated that resident #001 required the assistance of a mobility aid and two-staff for all transfers.

RPN #102 and RN #100 reviewed the written care plan with Inspector #554 and indicated that the written care plan is unclear in direction to staff who provide care as to resident #001's transfer requirements and staff assistance needed.

The DOC indicated to Inspector #554 that the written care plan for resident #001 provided unclear direction regarding how resident #001 is to be transferred and staff assistance needed.

The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide care to resident #001 specific to transfer requirements and assistance needed.

D) The MLTC received a complaint regarding the care and services provided to resident #002.

The complainant indicated to Inspector #554 that resident #002 required assistive aids and were not being maintained by staff.

PSW #103 indicated to Inspector #554 that resident required assistive aids that at times are maintained by a designated person and not the nursing staff. The assistive aids are not monitored for appropriate application by PSW staff.

The plan of care for resident #002, which included the written care plan was reviewed by Inspector #554. The review identified that resident #002 required the use of assistive aids. The written care plan which was in place at the time of the complaint and the current written care plan confirmed that the resident required assistive aids and confirmed that persons other than nursing staff maintain the assistive aids.

During a subsequent interview, PSW #103 indicated that the assistive aids are maintained by a designated person.

The document was reviewed by Inspector #554. The review identified assistive aids were not maintained weekly during identified dates as the person designated was not available.

PSW #103 confirmed that the assistive aids were not maintained weekly as required due to the to the designated person being unavailable.

PSW #103 and RN #100 indicated that was no direction in resident #002's plan of care related to the maintenance of the assistive aids when the designated person was unavailable.

The Administrator indicated to Inspector #554 that there should be clear direction to staff as to who was to maintain the assistive aids for resident #002 when the designated person was unavailable.

The licensee has failed to ensure that the plan of care for resident #002 set out clear directions to staff and others who provide direct care to the resident specifically related to the assistive aids. [s. 6. (1) (c)]

3. The licensee failed to ensure that the plan of care was provided to the resident as specified in the plan.

A CIR was submitted to the Director regarding an incident that caused injury to a resident for which the resident was transferred to hospital and which resulted in a significant change in the resident's health condition.

The plan of care for resident #001, including written care plans, were reviewed by Inspector #554. The written care plan identified that resident #001 was at risk for

falls and that interventions were in place related to falls prevention and management.

Inspector #554 observed resident #001 on three occasions during this inspection when falls prevention and management interventions were not in place or provided.

PSW #112 confirmed with Inspector #554 that there had been no safety device on resident's mobility aid during one of the observations. PSW #112 indicated being uncertain if resident required a safety device while in the mobility aid.

PSW #109 confirmed that resident #001 was at risk for falls and was required to have identified falls interventions in place, but was uncertain of specific fall intervention measures.

RPN #102 indicated to Inspector #554 that resident #001 was at risk for falls. RPN #102 indicated that interventions in place to prevent and manage falls for the resident, RPN indicated that interventions were to be provided as indicated in the plan of care.

The DOC and the Administrator indicated to Inspector #554 that staff are expected to follow the plan of care for each resident.

The licensee failed to ensure that the plan of care was provided to resident #001 as specified in the plan, specifically related to fall prevention and management interventions. [s. 6. (7)]

4. The licensee failed to ensure that the plan of care was revised and that different approaches were considered when the care set out in the plan was ineffective.

The MLTC received a complaint regarding the care and services provided to resident #002.

The complainant indicated to Inspector #554 that resident #002’s assistive aids are being frequently lost.

PSW #103 and RN #100 indicated to Inspector #554 that resident #002 is known to remove the assistive aids. PSW #103 confirmed that the assistive aids had been lost on occasion, required repair and or replacement. The PSW indicated

that nursing staff are to assist resident #002 in the application and removal of the aids. PSW #103 indicated awareness that complainant was frustrated with the aids being lost and needing repair.

The plan of care for resident #002, which included the written care plan and progress notes was reviewed by Inspector #554. The review identified that resident #002 required the use of assistive aids, that staff apply and remove assistive aids, check to ensure placement and proper storage.

Progress notes were reviewed indicated that resident #002 was known to remove assistive aids and misplace them. Progress notes documented fifteen times when resident's aids were lost and found, lost and not found, or found needing repair or were broken.

The plan of care failed to provide documentation to support that different approaches had been considered, specific related to the safety and security of resident #002’s assistive aids.

Resident #002 acquired new assistive aids during this inspection.

PSW #103 confirmed that resident had received new assistive aids and indicated that resident #002 continues to remove and misplaces them. PSW #103 indicated that no new interventions are in place related to the assistive aids. PSW #103 indicated that the safety and security of resident #002’s assistive aids remain a challenge.

RN #002 indicated to Inspector #554 being aware that resident #002 received new assistive aids. RN #100 and the Administrator indicated that no new interventions or approaches had been considered or implemented regarding the safety and security of resident #002’s assistive aids.

The licensee failed to ensure that the plan of care was revised and that different approaches were considered when the care set out in the plan was ineffective related to the safety and security of resident #002’s assistive aids. [s. 6. (11) (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 ensuring that the written plan of care for each resident sets out the planned care for the resident; that the plan of care was provided to the resident as specified in the plan; and that the plan of care was revised and that different approaches were considered when the care set out in the plan was ineffective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

The licensee failed to ensure that residents have their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and in the case of new items, of acquiring.

The MLTC received a complaint regarding the care and services provided to resident #002. The complaint included concerns regarding resident's assistive aids being lost and or damaged.

The plan of care for resident #002, which included the progress notes, was reviewed by Inspector #554. The review indicated that resident #002 required assistive aids and is known by the staff to remove them contributing to the aids being lost or misplaced. Documentation in the progress notes, by registered nursing staff indicated that resident's aids were lost on occasions and found, that one of the aids went missing and was not located and that the other aid was lost

and then found broken.

During the inspection a registered nursing staff documented in a progress note that resident #002 had received new assistive aids and were in use by resident #002.

PSW #103 confirmed that resident #002 had received new aids. PSW #103 indicated that the new aids were not labelled.

The licensee has failed to ensure that resident #002's assistive aids were labelled.

2. Resident #007 wears assistive aids and is dependent on staff for activities of daily living.

Resident #007 indicated that the assistive aids were not labelled.

RPN #108 indicated being unaware of the policy or process around the labelling of personal care items.

The Administrator indicated to Inspector #554 that personal care items are labelled upon admission and should be labelled when staff identify the label as being worn off. The Administrator indicated being unaware of the policy or process surrounding the labelling of personal care items following admission.

The licensee has failed to ensure that resident #007's personal care items were labelled. [s. 37. (1) (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 ensuring that residents have their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and in the case of new items, of acquiring, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff

upon any return from hospital.

A complaint was received by the MLTC on regarding the care and services provided to resident #007 by the licensee and the staff.

The plan of care, including progress notes and assessments, for resident #007 was reviewed by Inspector #554.

The progress notes confirmed that the resident had fallen, sustained an injury and was sent to the hospital for treatment.The resident returned to the home and had a prescribed treatment.

There is no documentation in the health record to indicate that resident #007 received a skin assessment upon return to the long-term care home.

RPN #108 and RN #100 indicated that residents returning from the hospital are to have a head to toe assessment upon return to the long-term care home. Both registered nursing staff indicated that the head to toe skin assessment would be in the resident's health record, in the assessments section, as well as captured in the progress notes.

RPN #108 indicated being aware that resident #007 returned to the long-term care home following treatment at the hospital. RPN #108 indicated working on the shift when resident #007 returned. RPN #108 was unable to recall if resident #007's skin integrity had been assessed upon return to the long-term care home. RPN #108 reviewed the plan of care with Inspector #007 and confirmed that there was no documented head to toe assessment completed.

RN #100 reviewed the plan of care for resident #007 with Inspector #554 and confirmed that there was no documented skin assessment for resident #007 upon return to the long-term care home.

The DOC indicated to Inspector #554 during an interview that resident #007's skin assessment had not been completed following resident's return to the long-term care home.

The licensee has failed to ensure that resident #007 received a skin assessment by a member of the registered nursing staff upon return from hospital. [s. 50. (2) (a) (ii)]

2. The licensee failed to ensure that the resident exhibiting altered skin integrity, including wounds, received immediate treatment and interventions to promote healing and prevention infection.

A complaint was received by the MLTC regarding the care and services provided to resident #007 by the licensee and the staff.

RPN #108 and RN #100 indicated that residents are to be assessed for altered skin integrity upon return to the long-term care home. Both registered nursing staff indicated that if altered skin integrity is identified that registered nursing staff would indicate the identified area in a skin assessment, in a progress note and on the eTAR. RPN #108 and RN #100 indicated that treatment protocols would be implemented, and that the physician would be advised of the skin issue and that the physician would direct treatment.

RN #100 reviewed the plan of care for resident #007 with Inspector #554 and confirmed that there was no treatments or interventions in place for resident #007 to promote healing. RN #100 indicated that resident's treatment had not been identified during return to the long-term care home and therefore orders related to the treatment had not been obtained. RN #100 indicated that the complainant had raised concerns regarding a treatment.

The DOC indicated that physician orders specific a treatment should have been obtained upon resident's return to the long-term care home from the hospital.

A physician’s order for treatment was obtained and the treatment was completed by registered nursing staff.

The licensee has failed to ensure that resident #007 who exhibited altered skin integrity received immediate treatment and interventions to promote healing. [s. 50. (2) (b) (ii)]

3. The licensee failed to ensure that a resident exhibiting altered skin integrity has been assessed at least weekly by a member of the registered nursing staff.

A complaint was received by the MLTC regarding the care and services provided to resident #007 by the licensee and the staff.

The complainant indicated that the resident had a fall, sustained injury, was transferred to hospital, required treatment and returned to the long-term care home. The complainant indicated that a treatment was not provided during identified dates. The SDM indicated that resident #007's treatment was not assessed by registered nursing staff and or the physician following return from the hospital.

The plan of care, including progress notes, assessments, physician orders, medication and treatment administration records for resident #007 was reviewed by Inspector #554.

The progress notes confirmed that the resident had fallen, sustained an injury and was sent to the hospital for treatment.The resident returned to the home and had a prescribed treatment.

The plan of care, including skin assessments, physician orders, electronic medication administration records (eMAR) and eTAR were reviewed for identified dates. The review failed to provide support that a weekly skin assessment had been completed related to the treatment.

RN #100 reviewed the plan of care for resident #007 with Inspector #554 and confirmed that weekly skin assessments had not been completed. RN #100 indicated that a weekly skin assessment should have been completed related to the treatment. RN #100 indicated that complainant had raised concerns regarding the treatment not being assessed by registered nursing staff.

The DOC indicated that resident #007's treatment should have been assessed upon return from hospital then weekly until it healed. The DOC confirmed that treatment had not been assessed weekly.

The licensee had failed to ensure that resident #007's treatment had been assessed at minimum, weekly by a member of the registered nursing staff.

During this inspection Inspector #554 identified non-compliance related to residents exhibiting altered skin integrity not assessed weekly by registered nursing staff. Further non-compliance related to O. Reg. s. 50 (2) (b) (iv) was identified related to resident #008 and resident #009.

Related to Resident #008:

Resident #008 was admitted to the long-term care home on an identified date. A Head to Toe Assessment and progress notes indicated that resident#008 was assessed as having compromised skin integrity.

The plan of care, including progress notes and skin assessments were reviewed by Inspector #554. The review identified resident #008 was assessed to have altered skin integrity and that treatment was provided by RPN #118.

The plan of care specifically progress notes and skin assessments failed to support that an area of altered skin integrity was assessed weekly following the initial assessment.

During subsequent dates, resident #008 was identified to have further alterations in skin integrity. RPN #116 and RPN #118 assessed and provided treatment as per protocols.

The plan of care specifically progress notes and skin assessments failed to support that the altered skin integrity identified and provided treatment was reassessed weekly.

RN #100 reviewed the plan of care for resident #008 with Inspector #554 and confirmed that a weekly skin assessment had not been completed.

The DOC indicated to Inspector #554 during an interview that weekly skin assessments are to be completed for all residents exhibiting altered skin integrity.

The licensee has failed to ensure that resident #008 who exhibited altered skin integrity was assessed weekly by a member of the registered nursing staff.

Related to Resident #009:

Resident #009 was admitted to the long-term care home. RN #100 indicated in an admission progress note that resident #009 was identified as having altered skin integrity. A head to toe skin assessment was completed and RPN#117 indicated that resident #009 had compromised skin integrity; the assessment does not specify the area of comprised skin integrity. The Head to Toe Skin Assessment indicated that additional assessments were required, specifically Weekly Impaired Skin Integrity Assessments.

RN #100 indicated that registered nursing staff are to assess any residents who exhibit skin breakdown weekly. RN #100 indicated that registered nursing staff are to assess the identified skin breakdown using the Weekly Impaired Skin Integrity Assessment in PCC and document the assessment in the progress notes.

The plan of care for resident #009 was reviewed by Inspector #554. The plan of care including progress notes, skin assessments and electronic treatment administration records indicated the following:

A progress note indicated that resident #009 was assessed by RPN #116 to have altered skin integrity. RPN #116 indicated that a specific treatment was provided. The Weekly Impaired Skin Integrity Assessment was completed. Later that day, RPN #118 assessed resident #009 to have further alteration in skin integrity. The Weekly Impaired Skin Integrity Assessment was completed and treatment was provided. Further review identified that resident #009 was identified to have further skin breakdown during other dates and that treatments were provided.

The review failed to identify that the areas of skin breakdown were assessed weekly by registered nursing staff.

RN #100 indicated that resident #009 had altered skin integrity. RN #100 reviewed the plan of care for resident #009 with Inspector #554 and confirmed that a weekly skin assessment had not been completed.

The DOC indicated to Inspector #554 that weekly skin assessments are to be completed for all residents exhibiting altered skin integrity.

The licensee has failed to ensure that resident #009 who exhibited altered skin integrity was assessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 ensuring that the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital; that the resident exhibiting altered skin integrity, including wounds, received immediate treatment and interventions to promote healing and prevention infection; and that a resident exhibiting altered skin integrity has been assessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee failed to ensure that a resident, who is incontinent and has been assessed as being potentially continent or continent some of the time, receive the assistance and support from staff to become continent or continent some of the time.

The MLTC received a complaint regarding the care and services provided to resident #002. The complaint included concerns regarding continence care and management.

The complainant indicated that concerns regarding care and services provided to resident #002 have been communicated to the Administrator, the DOC and the registered nursing staff on several occasions both verbally and in writing. The complainant indicated allegations of neglect specifically that resident #002 was not provided continence care.

The plan of care for resident #002 was reviewed by Inspector #554.

The written care plan indicated resident #002's continence level and identified specific interventions in place.

Inspector #554 observed resident #002 seated in a mobility aid and verbally request staff assistance. Inspector #554 observed PSWs #103 and #104 walk past resident #002 without acknowledging resident’s request to use the washroom; resident was then taken to the dining room without being assisted. The observed incident was reported by the Inspector to the Administrator and to RN #100.

PSW #103 indicated to Inspector #554 resident's continence level and indicated that resident will ask to use the washroom. PSW #103 indicated that resident #002 would have been toileted that morning. PSW #103 indicated that the resident home area is very busy, and that staff do their best to provide care to the residents.

RN #100 confirmed resident's continence level and indicated that resident will ask to use the washroom. The RN indicated that resident is to be toileted routinely and when the resident requests.

The licensee has failed to ensure that resident #002, who has been assessed as being potentially continent or continent some of the time, received the assistance and support from staff to be continent or potentially continent.

2. A complaint was received by the MLTC regarding the care and services provided to resident #007 by the licensee and the staff.

Resident #007 indicated to Inspector #554 that the long-wait times for the washroom had become an ongoing problem. Resident indicated being independent with toileting prior to an identified injury and since has had to rely on staff for continence care. Resident #007 indicated wait times for assistance are long and resulted in incontinence and discomfort.

PSW #106 and RN #100 indicated that resident #007 can express the need to use the washroom. Both PSW#106 and RN #100 indicated that staff are to provide assistance to resident #007 when the resident requests the need.

Resident #007 indicated that there had been three occasions where staff had not provided assistance in a timely manner and that such resulted in incontinence and discomfort.

Inspector #554 reported the alleged neglect incidents and details, as communicated by resident #007, to the Administrator and the Regional Director.

The Administrator indicated to Inspector #554 that the alleged neglect, failure to provide continence care and management was founded for one of the three incidents reported to have occurred to resident #007 and indicated that the other incidents were still being investigated.

The licensee failed to ensure that resident #007, who had been assessed as being potentially continent or continent some of the time, received the assistance and support from staff. [s. 51. (2) (d)]

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 ensuring that a resident, who is incontinent and has been assessed as being potentially continent or continent some of the time, receives the assistance and support from staff to become continent or continent some of the time, to be implemented voluntarily.

WN #6: 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 :

The licensee failed to ensure that strategies were developed and implemented for each resident demonstrating responsive behaviours.

The MLTC received a complaint regarding the care and services provided to resident #002.

The complainant indicated that resident #002 was not being provided planned care and not consistently receiving a physician ordered medication. The complainant indicated that the inconsistency in the administration of the medication is contributing to resident #002's assistive aid not functioning properly.

PSW #103 indicated to Inspector #554 that resident #002 can exhibit an identified responsive behaviour.

The plan of care, including progress notes, written care plan, physician orders, eMAR, and care records, was reviewed by Inspector #554. The review identified that resident #002 required assistance of staff for care and identified that specific interventions were in place. Care records identified that resident #002 had exhibited an identified responsive behaviour.

The physician’s orders indicated that resident #002 was prescribed a medication. The eMAR was reviewed by Inspector #554, the review indicated that resident #002 had exhibited the identified responsive behaviour in association with the medication administration. The eMAR for resident #002 identified that the

physician ordered medication had not been consistently administered to resident #002 due to an exhibited responsive behaviour.

The plan of care did not identify that strategies had been developed or implemented related to the exhibited responsive behaviour.

RN #100 confirmed that resident #002 was known to exhibit a responsive behaviour and indicated that interventions should have been identified in the resident's plan of care.

The DOC and the Administrator confirmed that strategies should be in place for any resident exhibiting a known responsive behaviour.

The licensee has failed to ensure that strategies were developed and implemented for resident #002 who was known to demonstrate responsive behaviours. [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 ensuring that strategies were developed and implemented for each resident demonstrating responsive behaviours, to be implemented voluntarily.

WN #7: 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. (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 :

The licensee failed to ensure that a documented record was kept in the home that included the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for action 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.

A complaint was received by the MLTC regarding the care and services provided to resident #007 by the licensee and the staff.

The complainant indicated voicing verbal and written complaints regarding the care of the resident to the nursing staff, the DOC and the Administrator without avail. The complainant indicated concerns are not being addressed to their satisfaction.

RN #100 indicated being aware that the complainant had voiced specific care concerns. RN #100 indicated that the complainant and others voiced displeasure with the care resident was receiving. RN #100 indicated that complainant had voiced concerns in writing and verbally voiced the concerns to the staff and management. RN #100 indicated that the written complaint was provided to the either the DOC or the Administrator following a meeting.

The plan of care for resident #007 was reviewed by Inspector #554. The review confirmed that the complainant had voiced care concerns to nursing staff, the physician, the DOC, the Administrator and others during meetings. Documentation indicated concerns were related to care of resident #007, a fall and a treatment.

The Administrator indicated being aware that the complainant had concerns regarding care, and indicated that complainant had voiced some concerns at meeting, but was unable to details specific to the date of the meeting or details of the complainants concerns. The Administrator indicated being aware of the letter of complaint being read verbally by complainant but indicated not being in receipt of the written complaint from the complainant, indicating that the DOC may have a copy of the written complaint.

The DOC indicated being aware of concerns voiced by the complainant but indicated being unable to recall specific concerns other than an identified treatment not being provided to the resident during return to the long-term care home. The DOC indicated being aware of letter of complaint read by the complainant at a meeting but indicated having no awareness of the complainant leaving a copy of the written complaint.

The DOC and Inspector #554 reviewed the plan of care. The DOC indicated having no documentation as to the details of each concern voiced by the complainant. The DOC further indicated having no documentation specific to the actions taken to resolve the complainants concerns, time frames for action to be taken or dates of follow up with complainant. The DOC indicated that the concerns regarding the treatment was resolved once a physician’s order was obtained but was unable to provide a date of the resolution. The DOC indicated belief that concerns of the complainant had been resolved.

The Administrator indicated that there was no documented record of the nature of each verbal complaint received by staff and managers at the meeting held with the complainant and indicated having no record of the type of action taken to resolve the complaints, final resolution and dates that a response or responses were made to the complainant specific to concerns.

The licensee had failed to ensure that a documented record was kept in the home that included the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint,

including the date of the action, time frames for action 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, specifically complaints raised by complainant during a meeting. [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 ensuring that a documented record was kept in the home that included the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for action 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, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

The licensee failed to ensure that a written report was submitted to the Director regarding a written complaint received pursuant to section 24 of the Act, specifically related to alleged neglect of a resident by the license or staff.

The MLTC received a complaint regarding the care and services provided to resident #002.

The complainant indicated to Inspector #554 that written complaints regarding care of resident #002 had been sent to the Administrator and the Director of Care. The complainant indicated that resident #002 was being neglected.

The Administrator confirmed being in receipt of written complaints from the complainant. The Administrator provided Inspector #554 with the written complaints.

One written complaint alleged that resident #002 had not been provided or assisted with care. The complainant indicated being concerned with the ongoing care issues.

Another written complaint alleged that resident #002 had not been appropriately groomed and had not been provided a meal on a specific date, indicated that resident's safety device had not been consistently provided and voiced concerns regarding an odour.

The Administrator indicated to Inspector #554 that written complaints could be alleged neglect. The Administrator indicated being aware of the reporting requirement related to section 24 of the Act. The Administrator indicated that a report had not been submitted to the Director.

The licensee has failed to ensure that a written report was submitted to the Director regarding a written complaint received pursuant to section 24 of the Act, specifically related to alleged neglect of resident #002. [s. 103. (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 ensuring that a written report was submitted to the Director regarding a written complaint received pursuant to section 24 of the Act, specifically related to alleged neglect of a resident by the license or staff, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

The licensee failed to immediately forward any written complaints received to the Director concerning the care of a resident or the operation of the home.

The MLTC received a complaint regarding the care and services provided to resident #002.

The complainant indicated to Inspector #554 that written complaints regarding care of resident #002 had been sent to the Administrator and the Director of Care.

The Administrator confirmed being in receipt of written letters of complaints from the complainant. The Administrator provided Inspector #554 with the written complaints. The Administrator indicated that the written complaints had been forwarded to the Director but could not provide submission dates, indicating that the information is not kept.

Inspector #554 contacted Central Intake, Assessment and Triage Team (CIATT) regarding submission of the written complaints regarding the care concerns related to resident #002.

CIATT indicated to Inspector #554 in an email correspondence that the written complaints received by the licensee or designate of Port Perry Place had been submitted to the Director but indicated that two of the written complaints were not immediately forwarded.

The Administrator indicated to Inspector #554 being aware that written complaints were to be immediately submitted to the Director. The Administrator indicated being unaware that the two of the written complaints were late being submitted.

The licensee failed to immediately forward written complaints received to the Director concerning the care of a resident or the operation of the home, specifically regarding the care of resident #002. [s. 22. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

The licensee failed to ensure that a resident is provided with any eating devices, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The MLTC received a complaint regarding the care and services provided to resident #002.

The complainant indicated to Inspector #554 that resident #002 requires eating assistance. The complainant indicated that resident #002 was not consuming adequate fluids.

The plan of care for resident #002, which included the written care plan was reviewed by Inspector #554. The review identified that resident #002 had interventions specific to nutrition and hydration included use of assistive aids.

Resident #002 was observed by Inspector #554 to have an assistive aid for cold beverages but not the hot beverage and was not provided with another identified assistive aid during mealtime observations.

PSW #103 indicated to Inspector #554 that resident was known to spill beverages but indicated that staff assist resident with beverages. PSW #103 indicated that resident #002 uses an assistive aid for beverages but is known to drink from a regular cup. PSW #103 indicated being uncertain if resident #002 was to have another assistive aid during mealtimes.

RPN #105 indicated to Inspector #554 that resident #002 can drink from a regular cup and does not always have an assistive aid for beverages.

Nutrition Manager indicated to Inspector #554 that resident #002 was assessed as needing assistive aids for food and fluids.

The licensee has failed to ensure that resident #002 was provided with assistive aids for food and fluids. [s.73 (1) 9.]

Issued on this 20th day of February, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JACK SHI (760) - (A1)
Inspection No. / No de l'inspection :	2019_716554_0007 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	006802-19, 018471-19, 020465-19, 020469-19, 020519-19, 020603-19, 020621-19 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 20, 2020(A1)
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
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 :	Laura Powell

To 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.), you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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 # / No d'ordre: 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. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, s. 19.

Specifically the licensee must:
a) ensure that all staff and managers are educated on the definition of and what constitutes neglect of a resident;
b) ensure all registered nursing staff and nursing managers are provided education regarding the licensee's skin and wound prevention and management program, specifically required skin assessments upon return from hospital, the provision of immediate treatment to promote healing and prevent infections and weekly skin assessments;
c) a documented record of this training is to be kept on file at the long-term care home.

Grounds / Motifs :

1.
The licensee failed to ensure that resident #007 was free from neglect by the licensee or staff in the home.

Pursuant to O. Reg. 79/10, s. 5, for the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A complaint was received by the Ministry of Long-Term Care regarding the care and

services provided to resident #007 by the licensee and the staff.

The complainant indicated to Inspector #554 that the resident had a fall, sustained injury, was transferred to hospital and required treatment. Resident #007 returned to the long-term care home and was not assessed for a number of weeks. The complainant indicated that the lack of assessment of resident #007 was considered neglect of care.

The plan of care, including progress notes, skin assessments, physician orders, electronic medication administration records (eMAR) and electronic treatment administration records (eTAR) for resident #007 was reviewed by Inspector #554.

The progress notes confirmed that the resident had fallen, sustained an injury and was sent to the hospital for treatment.The resident returned to the home and had a prescribed treatment.

The plan of care, including progress notes, skin assessments, physician orders, eMAR and eTAR, was reviewed for identified dates. The review failed to support that resident #007 had received a skin assessment upon return to the long-term care home from the hospital, failed to support that treatments or interventions were implemented to promote healing and failed to support that resident #007 received weekly skin assessments. (Refer to WN #4)

RPN #108 and RN #100 indicated to Inspector #554 during an interview residents returning to the long-term care home from hospital are to have a head to toe assessment. Both registered nursing staff indicated that if altered skin integrity is identified the information would be documented in a skin assessment, a progress note and on the eTAR. RPN #108 and RN #100 indicated that the skin and wound protocols would be implemented, and that the physician would be advised of the skin issue for treatment direction.

RN #100 reviewed the plan of care for resident #007 with Inspector #554 and confirmed that there were no treatments or interventions in place for resident #007 to promote healing. RN #100 indicated that the complainant had raised concerns regarding the treatment.

RN #100 indicated that it was a PSW who had raised concerns, to the registered

nursing staff suggesting the resident required treatment. RN #100 indicated that there should have been a physician order obtained when the resident returned to the long-term care home from hospital specific to resident's treatment. RN #100 indicated that following the discovery of the required treatment by a PSW, the resident's physician was contacted for orders.

The health record, for resident #007, indicated that an RPN contacted the resident's physician to obtain orders for treatment. On the same date treatment was provided to resident #007.

The DOC indicated to Inspector #554 during an interview that physician orders related to the required treatment should have been obtained upon the resident's return to the long-term care home and indicated that resident #007 should have had at a minimum, weekly skin assessments. The DOC indicated being aware that the complainant had raised concerns regarding resident #007's care.

The licensee has failed to ensure that resident #007 was free from neglect by the licensee or staff in the home, specifically regarding an area that was not assessed upon the resident's return to the long-term care home from hospital, was not provided immediate interventions or treatments and did not receive weekly skin assessments.

Additionally, the licensee failed to ensure the written plan of care for resident #007 provided clear direction to staff related to the application and use of recommended assistive aids. (WN #2, VPC); and the licensee failed to ensure resident #007 received toileting assistance from staff to support continence and maintain dignity (WN #5, VPC).

The severity of this issue was determined to be a level three as there was actual risk of harm to the resident. The scope was a level one as the risk of harm was related to resident #007. The licensee had no compliance history related to LTCHA, s. 19 (1). (554)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2020(A1)

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 20th day of February, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JACK SHI (760) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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Ordre(s) de l'inspecteur

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Service Area Office / Bureau régional de services : Central East Service Area Office