Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: September 23, 2024	
Inspection Number: 2024-1138-0003	
Inspection Type: Complaint Critical Incident	
Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)	
Long Term Care Home and City: Port Perry Place, Port Perry	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 27 to 30, and September 3 to 5, 2024.

The following intakes were completed in this complaint inspection:

One intake related to complaint regarding resident care and services.

One intake regarding complainant related to skin and wound care.

One intake related to complainant regarding infection prevention and control program, skin and wound care, safe and secure home, and food and nutrition.

The following intakes were completed in this Critical Incident (CI) inspection:

One intake related to infection prevention and control program.

Four intakes related to resident fall with injury.

One intake related to resident care and services.

The following **Inspection Protocols** were used during this inspection:

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and wound care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure resident was reassessed at least weekly by a member of the registered nursing staff when exhibiting altered skin integrity.

Rationale and Summary

A complaint was submitted to the Director alleging the resident was neglected for their skin and wound care.

A review of resident's electronic health records indicated that the resident had developed a pressure injury to their coccyx area.

The registered nursing staff was to complete a wound assessment tool in the resident's electronic chart at least on a weekly basis as per the home's skin and wound program policy. Upon further review of the resident's electronic chart, the wound assessment tool was not completed on two separate occasions.

Registered Nurse (RN) and the Director of Care (DOC) confirmed the same, and the assessment tool should have been completed on those dates.

There was a potential risk and impact to resident as the interprofessional team might not have obtained the most accurate wound assessment data.

Sources: Resident's electronic health records, and staff interview with RN and the DOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg.

246/22, s. 102 (9).

The licensee has failed to ensure that resident's symptoms indicating the presence of infection were recorded on every shift.

Rationale and Summary

The inspector reviewed the Infection surveillance of the home which identified residents with infections. Resident was noted to have an infection. The resident was prescribed treatment for the illness. According to the resident's progress notes, their infectious symptoms were not recorded on the night shift for the entire duration of the resident's treatment.

The Infection and Prevention and Control (IPAC) lead confirmed that the resident's symptoms were being monitored but should have been recorded on every shift during this time period.

Failing to record resident's infectious symptoms every shift may hinder staff from monitoring the resident and their response to the treatment.

Sources: Resident's clinical records and interviews with the IPAC lead.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (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 (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the

resident's health condition.

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

Rationale and Summary

The resident fell and sustained an injury, was sent to the hospital. Resident stayed in the hospital and did not return to the home. Resident was transferred from the hospital to hospice eventually.

There was a progress note indicating that the long-term care (LTC) home was aware of the significant change in the resident's health condition, via e-connect online. A Critical Incident System (CIS) Report was submitted to the Ministry of Long-Term Care (MLTC) later beyond one business day. The DOC confirmed during an interview that the incident was reported late and that the LTC home became aware of the injury with significant change in the resident's health condition.

There was no impact or risk related to the late submission of the CIS report to the Director.

Sources: Resident progress notes**,** CIS Report, interview with the DOC.

COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe

transferring and positioning devices or techniques when assisting residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1) Within two weeks of receipt of this compliance order- conduct audits on transfer techniques and the use of mechanical lifts, for the involved Personal Support Worker (PSW) twice weekly for four weeks to ensure the PSW knows when a mechanical lift needs to be used to transfer residents and how to transfer and lift residents safely.
2) The home is to develop and implement a mechanical lift safety checklist to verify safety features are functional at the beginning of every shift. The home is to educate all direct care staff and registered nursing staff on the process and requirements of the checklist.
3) Designate a nurse manager to review and sign off on the mechanical lift safety checklist at a minimum, once a week for four weeks, to ensure completion of the checklist.
4) The audits will be conducted by a member of the management team who has a demonstrated understanding of the safe lifting and transferring techniques.
5) The audits will include observations for safe and appropriate transfer techniques.
6) Provide on-the-spot instruction or direction required if issues are identified in the audits.
7) Keep a documented record of every audit, including the names of the auditors, a complete list of all steps that must be taken to safely lift and transfer a resident, audit completion dates and locations, and any on-the-spot instruction provided including a signature that the staff participated in the audit. Provide the audits to the Inspector immediately upon request.

Grounds
The licensee has failed to ensure that a Personal Support Worker (PSW) used safe transferring and positioning device when assisting resident #004.

Rationale and Summary

A CIS report was submitted to the Director indicating resident had fallen out of transfer sling when being transferred using a mechanical lift. The resident had to be immediately sent to a local medical facility for care and treatment.

The resident's plan of care indicated that the resident was to be transferred between surfaces using a mechanical lift with a Hammock sling by two staff members. As per the home's internal investigative notes, a PSW was the resident's primary PSW for the day shift on the day of the incident. The resident had to be transferred from their bed to their wheelchair using a mechanical ceiling lift in the room. The transfer sling was successfully applied in bed by the PSW, and the staff proceeded with connecting the transfer sling straps to the mechanical lift's carry bar hook. The resident remained well at that time and staff had initiated the transfer by lifting the resident off the bed. At that time, the PSW was demonstrating the transfer process to two PSW students for their learning. During the transfer, the resident suddenly exhibited jerking movement and caused one of the transfer straps to be unhooked from the carry bar. The resident then slid out from the transfer sling and fell on to the floor. The resident was observed to be crying and moaning and was immediately sent to a local medical facility for additional care and treatment.
Based on the home's internal investigative notes, it was identified that the safety latches on the carry hook bar were missing from the identified mechanical ceiling lift. As per the mechanical lift's instruction manual, the purpose of the safety latch was to lock the transfer strap to the carry hook bar and prevent the sling from disconnecting from the lift system.

When interviewed, the PSW was uncertain if the safety latches would need to be applied when connecting the transfer sling to the ceiling lift system and proceeded with transferring resident without the safety latches on the carry hook bar.

The DOC had confirmed that the safety latches were required to be applied when

connecting the transfer sling to the ceiling lift. Additionally, the PSW had completed the transfer by themselves, without a second staff as required. The DOC further confirmed that the staff had completed an unsafe transfer that resulted to an injury for the resident.

There was an actual risk of harm to resident as the resident sustained a fracture to their neck and subsequently passed away.

Sources: Resident's chart, home's internal investigative notes, and staff interviews with PSW , and the DOC.
This order must be complied with by November 29, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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