Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection 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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 28, 2017	2017_419658_0009	030908-16, 033082-16, 033556-16, 006152-17	Complaint

Licensee/Titulaire de permis

CVH (No. 5) GP Inc. as general partner of CVH (No. 5) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Country Village Homes - Woodslee
440 County Road 8 R. R. #2 Woodslee ON N0R 1V0

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

NEIL KIKUTA (658), ALISON FALKINGHAM (518)

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): June 19, 20, 21, 22, and 23, 2017.

Written Notification #4 is further evidence to support Compliance Order #001 issued on June 16, 2017, in Inspection #2017_531518_0008, with a compliance date of July 14, 2017.

A Written Notification under LTCHA, 2007, c. 8, s. 19 (1), identified in concurrent

inspection #2017_419658_0010 will be issued in this report.
A Written Notification under LTCHA, 2007, c. 8, s. 24 (1), identified in concurrent inspection #2017_419658_0010 will be issued in this report.
A Written Notification and Voluntary Plan of Correction under Ontario Regulation 79/10, s. 49 (2), identified in concurrent inspection #2017_419658_0010 will be issued in this report.

The following intakes were completed within this Complaint Report:

Complaint Log #030908-16, IL-47545-LO, related to prevention of abuse and neglect;
Complaint Log #006152-17, IL-49936-LO, related to prevention of abuse and neglect;
Complaint Log #033556-16, IL-48225-LO, related to prevention of abuse and neglect; and
Critical Incident Log #033082-16, CIS #2576-000023-16, related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Resident Program Manager, Office Manager, Physiotherapist, Physiotherapist Assistant, Registered Nurses, Registered Practical Nurses, Personal Support Workers, and Recreation staff.

The inspector reviewed clinical records and plans of care for relevant residents, pertinent policies, procedures, and program evaluations, and the staff schedule. Observations were also made of general maintenance, cleanliness, and condition of the home, infection prevention and control practices, provision of care, and staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Responsive Behaviours

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

5 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the resident’s behaviour patterns, including any identified responsive behaviours.

a) Review of an identified resident's progress notes indicated 10 incidents of responsive behaviours in a three month period.

On a specified date, two Personal Support Workers (PSW) explained that the resident exhibited several responsive behaviours towards staff.

Review of the identified resident's most recent care plan, as well as a historical search, showed that the resident displayed one form of responsive behaviours. From the resident’s admission to their discharge, the identified resident's care plan did not indicate two other forms of responsive behaviours that the progress notes and staff described.

On a specified date, the Resident Program Manager explained that they were also the Behavioural Supports Ontario (BSO) lead in the home. The Resident Program Manager clarified that the plan of care related to residents exhibiting responsive behaviours was captured in the resident's care plan located online or printed into a binder at each nursing station. The Resident Program Manager stated that the identified resident exhibited responsive behaviours, and could not identify these behaviours in the resident’s care plan. The Resident Program Manager expected that the identified resident's care plan related to responsive behaviours outlined what the behaviours were, their respective goals, and each intervention.

b) A Critical Incident System (CIS) report indicated that two staff had found an identified resident to be inappropriately touching another identified resident on a specific date.

Record review of the first identified resident's progress notes indicated five incidents of responsive behaviours towards staff and residents in a 10 month period.

On a specified date, a BSO PSW, a Registered Practical Nurse (RPN), and a Registered Nurse (RN) stated that the first identified resident exhibited responsive behaviours.

Review of the first identified resident's most recent care plan indicated that the resident had responsive behaviours. Historical review of the first identified resident's care plan showed no evidence of these responsive behaviours during two incidents involving two different residents. Although the first identified resident exhibited responsive behaviours that dated back to over a year ago, the first identified resident's care plan was not revised until three days after the fifth incident described in the progress notes to indicate responsive behaviours.

On a specified date, the Resident Program Manager reviewed the first identified resident's care plan and acknowledged that the responsive behaviour was not identified in the plan of care until three days after the fifth incident. The Resident Program Manager expressed that they expected the first identified resident's responsive behaviours to be in the care plan prior to fifth incident.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level two, related to potential for actual harm. There was a history of related non-compliance in the last three years as evidenced by a WN and VPC being issued in inspection report #2016_243634_0017. [s. 26. (3) 5.]

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 to ensure that a plan of care must be based on at a minimum, interdisciplinary assessment of behaviour patterns, including any identified responsive behaviours, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

a) Record review of risk management and progress notes showed that an identified resident had fallen on a specific date.

Risk management incident #38084 indicated that a post fall assessment was not created for this incident.

On a specified date, the Director of Care (DOC) stated that a post fall assessment was required to be completed for all falls. The DOC reviewed the identified resident’s risk management and assessments and acknowledged that there was no post fall assessment completed.

b) An identified resident was admitted to the long-term care home with multiple medical diagnoses, and a care plan that stated that the resident was at high risk for falls.

On a specified date, the identified resident was found on the floor. Staff assessed an area of altered skin integrity, and pain with passive range of motion.

Review of the identified resident's clinical records indicated no post fall assessment was completed.

The DOC stated their expectation was that a post fall assessment would be completed.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level two, related to potential for actual harm. There was a history of related non-compliance in the last three years as evidenced by a WN being issued in inspection report #2014_206115_0009. [s. 49. (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 to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation that could potentially trigger such altercations.

Record review of an identified resident's progress notes indicated eight incidents of responsive behaviours towards other residents in an 18 month period.

On a specified date, a Behavioural Supports Ontario (BSO) Personal Support Worker (PSW) explained that the identified resident was on the internal BSO program due to responsive behaviours towards staff and residents. The BSO PSW described a trigger that made the identified resident exhibit responsive behaviours towards other residents. Interviews with another BSO PSW and a Registered Practical Nurse (RPN) also indicated that they were aware of the identified resident's responsive behaviour trigger.

The identified resident's electronic care plan showed that the resident exhibited responsive behaviours as described by staff and documented in progress notes. The care plan did not identify, or ever identify factors such as the trigger described by the staff that could potentially trigger altercations and potentially harmful interactions between the identified resident and other residents.

The Resident Program Manager stated the identified resident's responsive behaviours, and the same trigger as described by the other staff. The Resident Program Manager reviewed the identified resident's care plan and could not find that the trigger as described was a trigger for the identified resident's altercations with other residents, and expected to find it in the care plan.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level two, related to potential for actual harm. There was a history of unrelated non-compliance in the last three years. [s. 54. (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 to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations, to be implemented voluntarily.

WN #4: 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 :

1. Written Notification #4 is further evidence to support Compliance Order #001 issued on June 16, 2017, in Inspection #2017_531518_0008, with a compliance date of July 14, 2017.

Ontario Regulation 79/10, s. 2(1) defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain", and “the use of physical force by a resident that causes physical injury to another resident.”

The licensee has failed to protect residents from abuse by anyone.

a) The Ministry of Health and Long-Term Care received a complaint regarding multiple occasions where an identified resident was found with injuries.

A review of progress notes outlined a history of interactions between the identified resident and another resident. The record review showed that the two residents had five documented incidents of altercations over a two month period. Two of the five incidents

involved one of the identified residents physically abusing the other identified resident.

On a specified date, an identified Personal Support Worker (PSW) explained that the responsive behaviours of the identified resident triggered the responsive behaviours of the other identified resident, and resulted in altercations. Another PSW and Registered Nurse (RN) reaffirmed these statements.

Review of an identified resident's care plan showed that the resident exhibited responsive behaviours, but did not identify factors such as the described trigger that could potentially result in altercations and harmful interactions between the identified resident and other residents.

The Director of Care (DOC) acknowledged that the incidents involving the two identified resident's constituted resident to resident abuse.

b) On a specified date, a PSW witnessed another PSW physically abusing an identified resident. The identified PSW reported this incident to the RN, but the RN did not contact the supervisor on call, or notify the Director (Ministry of Health and Long-Term Care).

On another specified date, a PSW heard yelling coming from an identified resident's room. The PSW looked in and witnessed an identified PSW physically abusing the identified resident.

The DOC stated that both these incidents were abusive in nature and committed by the same staff member who no longer worked in the home.

The scope of this area of non-compliance was determined to be patterned. The severity was determined to be a level three, related to actual harm. There was a history of related non-compliance in the last three years as evidenced by a WN and CO being issued in inspection report #2017_531518_0008. [s. 19. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred immediately reported the suspicion and the information upon which it was based to the Director.

Ontario Regulation 79/10, s. 2(1) defines physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain", and "the use of physical force by a resident that causes physical injury to another resident."

Ontario Regulation 79/10, s. 2(1) defines sexual abuse as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

Extendicare policy on Zero Tolerance of Resident Abuse and Neglect: Response and Reporting (RC-02-01-02), last updated in April 2016, stated in part that "any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time."

a) Record review of risk management and progress notes of an identified resident showed that on a specified date, a Registered Nurse (RN) documented that a Personal Support Worker (PSW) had heard the identified resident screaming. The PSW found an

identified resident hitting another identified resident. The RN documented that they had notified the on-call manager.

Further documentation showed that on another specified date, the identified resident was kicked by another identified resident. Documentation did not indicate whether a manager or supervisor was notified.

The identified RN stated that they did not remember which manager they had notified related to the first incident, and there was no documentation in either identified resident's medical health records.

The Director of Care (DOC) explained that all abuse was to be immediately reported to the Director (Ministry of Health and Long-Term Care). The DOC acknowledged that the incidents of abuse of the identified resident on the two separate dates were not reported to the Director (MOH), and should have been.

b) Critical Incident System (CIS) report related to abuse of an identified resident by another identified resident was reported to the Director (Ministry of Health and Long-Term Care) on a specified date.

Record review of progress notes indicated that the abuse occurred one day prior to the incident as described in the CIS report.

On a specified date, an identified Registered Practical Nurse (RPN) stated that they had reported the incident of abuse to an identified Registered Nurse (RN), and that it was the responsibility of the RN to notify the manager. The identified RN stated that they were notified of the incident involving the two identified resident's by the identified RPN, but did not notify the manager on call that night. The RN further explained that management had found out the next day.

The DOC stated that it was their expectation that the witnessed incident of abuse was immediately reported to the Director (MOH) through the after-hours phone number.

c) On a specified date, an identified resident was physically abused by an identified PSW. This was witnessed by another identified PSW, who reported the incident to an identified RN. The identified RN did not contact the Director (MOH) to report this abuse nor did they contact the manager on call.

On another specified date, an identified PSW heard yelling coming from an identified resident's room. The PSW looked in and witnessed another identified PSW physically abusing the identified resident. The identified PSW reported this to an identified RN at the end of the shift and then reported it to the former DOC on a specified date. At that time a CIS was submitted to the Ministry of Health and Long-Term Care.

The DOC stated that both of these incidents required immediate reporting to the supervisor on call, and the Director (MOH) due to the nature of the abusive acts and the risk of harm to the residents.

The scope of this area of non-compliance was determined to be isolated. The severity was determined to be a level two, related to potential for actual harm. There was a history of unrelated non-compliance in the last three years. [s. 24. (1)]

Issued on this 29th day of June, 2017

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

Original report signed by the inspector.