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

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559
ottawadistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: February 6, 2023	
Inspection Number: 2022-1287-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: CVH (No. 4) LP by its general partner, Southbridge Care Homes (a limited partner	
Long Term Care Home and City: Pinecrest (Plantagenet), Plantagenet	
Lead Inspector Julienne Ngo Nloga (502)	**Inspector Digital Signature** Julienne Ngo Nloga Digitally signed by Julienne Ngo Nloga Date: 2023.02.06 09:17:43 -05'00'
Additional Inspector(s) Laurie Marshall (742466)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 13, 14, 17-21, 25, 27 and 28, 2022.

The following intake(s) were inspected:

- Intake: #00001885 (CIS: 2797-000012-21) related to medication error.
- Intake: #00002719 (CIS: 2797-000010-21) and #00002958, #00002958 (CIS: 2797-000009-21) and #0002719 (CI: 2797-000010-21), #00003028 (CI: 2797-000011-21), related to resident to-resident behaviours.
- Intake: #00006104 related to multiple care concerns.
- Intake: #00007159 (CIS: 2797-000008-22) related to a fall with injury of a resident

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

Skin and Wound Prevention and Management
Pain Management

Falls Prevention and Management
Responsive Behaviours
Medication Management
Prevention of Abuse and Neglect
Infection Prevention and Control
Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Responsive Behaviours

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 53 (4)

The licensee has failed to ensure that, for two residents demonstrating responsive behaviours, (a) the behavioural triggers for the resident were identified, where possible, (b) strategies were developed and implemented to respond to these behaviours, where possible; and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Rationale and Summary
A) A resident's progress notes in 2021, indicated that the resident had displayed identified behaviours towards co-residents. The resident's care plan showed that the last revision was made in 2020 and directed staff to move the resident to a place with less stimuli.

One staff indicated that the resident's health condition had declined, and they depend on staff for all care needs. The risk of the identified behaviours had reduced. In separate interviews, three staff acknowledged that the care plans have not been reviewed and revised since 2021, when the resident exhibited the identified behaviours toward co-residents and staff.

By not reviewing and revising the resident's care plan, staff may not respond to the assessed need of the resident.

Sources: Progress notes, care plan. Interviews with staff. [502]

B) A resident had a history of specified behaviour toward other residents in the home.

Progress notes in 2021 showed that the resident was found exhibiting identified behaviours toward a co-resident and interventions were put in place.

Physician notes in 2021 indicated that the resident's medications were adjusted because of the resident increased identified behaviours toward co-residents.

The care plan for the resident showed other behaviours and interventions were documented to address those behaviours toward staff interaction. There was no intervention to address the identified resident's behaviours toward co-residents and no reassessment of these interventions when the behaviours continued.

Interviews with three staff indicated that the resident had a history of the identified bahaviours toward co-resident and staff. The interventions were limited to redirecting the resident; no specific interventions were in place to mitigate the resident's identified behaviours toward co-residents.

By not taking action to respond to the resident's needs, and mitigate their responsive behaviours towards co-residents, the co-resident remained at risk of the resident identified behaviours.

Sources: Progress notes, physician's notes, care plan. Interview with staff. [742466]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that residents were protected from abuse and neglect by staff.

Rationale and Summary:

A) As per O.Reg 246/22 s.2 (a) "emotional abuse" means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A resident reported that in September 2022, they requested assistance for care at two separate occasions during a shift. They waited one and half hour for the first request and two hours for the second request before two staff provided assistance. After the care, the staff did not assist them ambulate to their bed. The resident indicated that both staff were in the hallway discussing while they were waiting for assistance.

The resident indicated that was not the first time the staff ignored their request for assistance. The resident reported that they avoided drinking when both staff were working because the feared they would not be able to get assistance with care.

The resident reported that they wanted to move out of the home because they were afraid of calling for assistance and being ignored and not getting care on time.

The Administrator, and Licensee's Regional Director (RD) indicated that both staff neglected to provide care to the resident and their employment were terminated.

By not attending the resident's care needs, the resident sustained emotional abuse by being ignored by the staff when requesting assistance.

Sources: Interviews with the resident, Administrator, Licensee Regional Director. Home's investigation notes, staff's statements, staff's personal files, resident's progress notes and plan of care. [502]

B) As per O.reg 246/22 s.7 the definition of "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 resident reported that in September 2022, the outgoing staff started toileting care and they waited three hours for the incoming staff to completed the care. The resident stated that they did not sustain an injury, but they were uncomfortable as they were tired and sleepy.

Two Staff transferred the resident on the commode at the end of their shift, they reported to the other two incoming shift staff that the resident was seated on the commode. A third staff acknowledged that they were aware that the resident was on the commode, they told the resident that they would transfer them back to bed when staff returned from their break. Effort was not made to call the staff from their break leaving the resident for 3 hours on the commode.

The Licensee's Regional Director (RD) indicated that both staff provided improper care to the resident and were no longer at the home.

The resident was neglected and received improper care as they were left for approximate 3 hours on the commode.

Sources: Staff written statement, home's investigation, CIS report. Interviews with the resident, Administrator and Licensee Regional Director. [502]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)

The Licensee failed to protect resident #003 from sexual abuse by resident #002.

O.Reg. 79/10 s.2 (1) 3 (a) defines "sexual abuse" as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member.

Rationale and Summary
A resident's progress notes in 2021 showed two episodes where the resident was found displaying behaviours of non-consensual touching of a sexual nature toward a co-resident. Four months later, the resident was found in a specified care area with the co-resident displaying the same behaviour.

The plan of care for the resident did not identify focus, goals or interventions related to the behaviours of non-consensual touching of a sexual nature.

Three staff indicated that the resident had a history of the behaviours of non-consensual touching of a sexual nature towards the co-resident and another unidentified resident.
Two staff reported that the resident had history of the behaviours of non-consensual touching of a sexual nature toward the co-resident. They stated that attempts were made to protect the co-resident by relocating both residents to different areas of home; redirecting the resident away from the co-resident and keeping the co-resident with staff at shift change and meals to prevent attempts of the behaviours of non-consensual touching of a sexual nature. The co-resident was cognitively impaired and was dependent on staff for mobility and transfers.

By not preventing the resident's ongoing behaviours of non-consensual touching of a sexual nature, the co-resident remained at risk of the resident's behaviours of non-consensual touching of a sexual nature until the death of the resident six months after the first display of the behaviours.

Sources: Critical Incident report, Progress notes, interviews with staff. [742466]

WRITTEN NOTIFICATION: Drug Administration

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 114 (3) (a)

The home failed to implement policies regarding medication transcription in accordance with prevailing practices.

Rationale and Summary
Transcription of medication was not done as per home's policy regarding "Medication Reconciliation Form for Best Possible Medication History" in September 2021 for a resident.

Medication Incident report and analysis form in 2021 reports transcription medication errors citing "The prescription used to do the MAR was not the proper MAR".

Progress notes from in September 2021 state "Resident admission prescriptions contained three errors".

A staff reported verifying admission order information as a secondary nurse. A second staff reported that they discovered medication transcription error and completed the incident report, contacted the physician, and obtained new medication orders

Review of medication orders found that as per policy, medication reconciliation was not followed. Three medication transcription errors occurred in the admission medication reconciliation of the resident. The first medication which was not prescribed on readmission; the second medication was not transcribed into medication administration record (MAR) and the third medication was not transcribed as per discharge instructions for dose titration. By not following the home's transcription policy, the resident received a medication, that was not prescribed, and this could have led to adverse medication effects.

Sources: Medication Policy, Medication Incident Report, MAR, Progress Notes, Physician Order and interview with two staff. [742466]

WRITTEN NOTIFICATION: Drug Administration

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 131 (1)

The licensee has failed to ensure that no drug is used or administered to a resident in the home unless the drug has been prescribed.

Rationale and Summary
Physician order documentation showed that the resident was not prescribed a specified medication.

Medication administration record (MAR) shows that a staff administered one dose of the specified medication for two days in September 2021.

Interview with the staff reports that they discovered medication transcription error and completed the incident report, contacted the physician, and obtained new medication orders.

As such, the resident was administered an unprescribed medication and there was a risk of potential adverse medication effects.

Sources: Physician orders, MAR, Critical Incident Report, interview with a staff. [742466]

WRITTEN NOTIFICATION: Skin and Wound Assessment

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 50 (2) (b)

The licensee has failed to ensure that 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, and (ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Rational and Summary
The progress notes showed that a resident had a history of identified condition. On a day in 2021, the resident had specified altered skin integrities which were tender to touch to two areas of their body. From day 1 to day 7, the resident continued to have altered skin integrity to two areas of their body.

The resident's Minimum Data Set (MDS) showed a presence of two altered skin integrities to their body, staff to monitor and report any change to a nurse. The resident's plan of care did not identify a focus, goals or interventions related to the resident's impaired skin integrity.

A staff member indicated that the resident was admitted with a specified condition. They were rubbing the legs against a chair that led to skin breakdown. From day 1 to day 7, the resident had an altered skin integrities to one of the areas of the body. On day 7, the home did not respond to family's request to transport resident to hospital immediately, the dressings were being applied but a wound continued to deteriorate even with the application of dressings. and this led to further complications relating to skin breakdown and infection. On day 9, a staff noted increased skin breakdown to an area of the body with new onset of specified symptoms and subsequently led to their transfer to hospital for further assessment. The resident returned to the home 22 days later and had four other areas with skin breakdown.

By failing to do skin assessments for three weeks in 2021, the wound care interventions were not revised when the resident's condition continued to deteriorate and subsequently led to their transfer to hospital.

Sources: skin and wound assessment record, progress notes, MDS, Plan of care, eTAR. Document Survey Report. Interviews with a staff member. [502].

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect Policy

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 98

The licensee failed to ensure that the appropriate police force was immediately notified of witnessed alleged abuse of the residents

Rationale and Summary

In 2021, a resident was observed in displaying behaviours of non-consensual touching of a sexual nature toward a co-resident.

The Critical incident system report and a staff interview reported that police were not notified.

By not reporting the incident of alleged sexual abuse to the police the home did not comply with the legislation.

Sources: Progress notes, Critical report System. Interview with a staff [742466]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b)

The licensee failed to implement any standard or protocol issued by the Director with respect to infection prevention and control.

A) In accordance with additional requirement under the standard 9.1 (d) the licensee has failed to ensure that Proper use of PPE was followed in the IPAC program, including appropriate selection, application, removal, and disposal.

Rationale and Summary
The inspector observed a staff in 2022, providing care to a resident without wearing Personal Protective Equipment (PPE). The resident was in contact precaution for identified infection. Four days later, the Inspector observed another staff providing care to another resident who was under contact precaution an identified infection. A contact precaution sign was posted at the door of each resident

Both staff indicated that they were aware that they should wear PPE before providing care to any resident in contact precaution. They did not pay attention to infection control signage prior to entering the resident's room, therefore they had no idea that the resident required contact precaution during the provision of care.

The IPAC lead indicated that staff were provided with a colour coding resident list to identify required

additional precautions for each resident. In addition, to the infection control signage at the resident bedroom entrance doors, and daily changes in IPAC were discussed daily during shift change.

By not wearing proper PPE, the residents were exposed to cross-contamination.

Sources: Inspector's observation, Infection control signage, Colour coding resident list. Interviews with two Staff, and IPAC lead. [502]

B) The licensee shall implement any standard or protocol issued by the Director with respect to infection prevention and control.
In accordance with additional precaution under 10.4 (h), the licensee has failed to ensure that residents were supported to perform hand hygiene prior to receiving snacks.

The Inspector observed that staff did not assist residents to perform hand hygiene prior to serving snacks in two different days in 2022. Two staff indicated that hand hygiene was not completed because the residents were in their environment

IPAC Lead indicated that the practice was to provide hand hygiene prior and after meals using Alcohol Based Hand Sanitizer (ABHS) and that was communicated to staff. They acknowledge that was identified during self-assessment audits and they continue working to highlight the importance of hand hygiene before meals and snacks.

By not assisting residents in performing hand hygiene the residents were at risk for cross contamination.

Sources: Inspector's observation. Interview with two staff, and IPAC Lead. [502]

C) The licensee shall implement any standard or protocol issued by the Director with respect to infection prevention and control.
In accordance with additional precaution under 9.1 (e) (i) the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program at minimum Routine Practices shall include use of environmental controls, including but not limited to, location/placement of residents' equipment and cleaning.

One staff was observed not sanitizing their specified equipment between two resident's care. The first resident was in isolation due identified infection and the second resident was not in any additional precaution.

The staff indicated that they did not pay attention to infection control signage prior to entering the resident's room, therefore they had forgotten to sanitize their equipment.

The IPAC Lead indicated that when providing exercise to a resident and physically touching a resident constituted direct care, which staff should follow infection control directions and sanitize their equipment that was shared between residents. Staff not wearing the appropriate PPE, residents were at risk for cross contamination.

Sources: Observations. Interviews with PTA and IPAC lead. [502]

WRITTEN NOTIFICATION: Safe Transferring

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 40

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

Rationale and Summary
In 2022, the Inspector observed a staff transferring a resident from bed to wheelchair with a mechanical lift without the assistance of a second staff. The care plan indicated that the resident required total assistance and a use of mechanical lift.

The home's Resident Handling Procedures directs staff not to proceed with a lift if problems with equipment, environment, staff readiness or resident readiness are identified.

The resident indicated it was not the first time they were transferred by one staff, this occurred during shifts with shortage of staff. The staff indicated that they transferred the resident without assistance as they were three staff short. They were not directed to transfer the resident without assistance.

The Administrator and licensee's Regional Director indicated that all lift transfers require two staff assistances, and staff were directed to call registered nursing staff or management staff if other staff were not available to assist with transfer.

By transferring the resident unassisted with a mechanical lift, the staff put the resident at risk of fall and injury.

Sources: Safe lifting with care, care plan, observation, interview with PSW, Administrator, and Licensee's Regional Director [502]

WRITTEN NOTIFICATION: Housekeeping

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 93 (2) (a)

The licensee has failed to comply with written procedures related to cleaning the resident rooms.

Specifically, the licensee did not comply with the home's Isolation Room Cleaning Procedure #HL-05-0118. Revised in January 2022, which is part of the organized program of housekeeping.

Rationale and Summary
The home's policy directs staff to clean isolation rooms last to reduce the risk of cross contamination. Housekeeping staff was observed on two different days in 2022, cleaning the residents' room, one room after another starting at the end of the hallway, including rooms with a contact precaution signage.

A staff indicated that they started cleaning the last room on the hallway and continued one room after another. They changed soiled water after cleaning two to three resident's room, or if the room was very dirty or soiled with urine.

In joint interview, IPAC lead and the Licensee IPAC lead indicated that staff were expected to clean room not in isolation first, then the isolation rooms last, and that was communicated to staff during their orientation.

By not following the home's cleaning procedure, housekeeping staff increase the risk of cross contamination between rooms.

Sources: Inspector's observation. Isolation Room Cleaning Procedure #HL-05-0118. Interviews with Staff, IPAC lead and the Licensee IPAC lead. [502]