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
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Original Public Report

Report Issue Date: June 23, 2023

Inspection Number: 2023-1287-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: CVH (No. 4) 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: Pinecrest (Plantagenet), Plantagenet

Lead Inspector	**Inspector Digital Signature**
Julienne NgoNloga (502)	Julienne Ngo Nloga Digitally signed by Julienne Ngo Nloga Date: 2023.07.14 11:18:32 -04'00'

Additional Inspector(s)
Joelle Taillefer (211)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
- onsite March 30, 2023, April 3, 12-13, 18-21, 24- 26, 2023, and May 1-2, 2023.
- offsite March 29, 2023, and April 4, 2023.

The following intake(s) were inspected:
Critical Incident Report (CIS)
- Intake: #00003047 (CIS #2797-000002-22) related to an unexpected death of a resident.
- Intakes: #00004072 (CIS #2797-000015-21), #00015661 (CIS #2797-000019-22) related to allegation of neglect of residents.
- Intake: #00010937 (CIS #2797-000017-22) related to allegation of abuse from resident to resident.

Complaints
- Intake: #00010751 related to multiple care concerns.
- Intake: #00012718 related to an allegation of abuse from a staff member to a resident.
- Intake: #00020829 related to a misappropriation of funds.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Resident Charges and Trust Accounts

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (6)

The licensee has failed to ensure that, within the times provided for in the regulations, a resident was assessed on admission, and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement coordinator under section 44.

Rationale and Summary
A resident's heath care record indicated that the resident was admitted to the home in January 2022. their assessment Instrument - Minimum Data Set (RAI-MDS) was completed, but the initial plan of care based on the RAI-MDS assessment had not been completed.

The Director of Care (DOC) and the Executive Director (ED) acknowledged that the initial plan of care was not initiated.

As such, staff members were not aware of the resident's care needs and preference during the provision of care.

Sources: Resident health record, PCC, and staff members interviews.
[502]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #002 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 has failed to ensure that a resident was protected from neglect by staff.

Rationale and Summary:
As per O.Reg. 79/10 s. 5 "neglect" means the inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A staff member had accidentally fell out a resident's specified care equipment while providing morning care. Another staff member contacted the Director of Care (DOC), who told them to transfer the resident to hospital for a replacement procedure. A registered nursing staff on duty contacted the attending Physician for a verbal order, and then they performed a replacement procedure on site using an alternate equipment, instead of transferring the resident to hospital as the DOC directed. The specified care resumed after the procedure.

The progress notes indicated that after the procedure using alternate equipment was completed, the resident had identified side effects during care. Staff continued to provide care using the alternate equipment until it fell out of the resident the next day. The following day, the resident's health condition deteriorated, and the resident was transferred to hospital.

A second staff member reported that the registered nursing staff gave directions for food and medication intake to continue using the alternate equipment. They stated that they had not taken the vital signs as it was not the first time that the alternate equipment was used.

A staff member reported they informed the registered nursing staff that the resident was having inadequate intake with the alternate equipment and the registered nursing staff did not transfer the resident to hospital.

The DOC indicated that the alternate equipment is used as a temporary measure and should have not been used for the resident intake unless the placement was checked in hospital. The DOC stated that the vital signs should have been taken before and after the placement of the alternate equipment. They stated that all registered nursing staff, who worked during the 48 hours period did not take the vital signs until the resident was transferred to the hospital.

By using the alternate equipment for food and medication intake without checking the placement in hospital, and not taking the vital signs, registered nursing staff neglected the resident by failing to provide the resident with the treatment, care, services or assistance required for health, safety or well-being.

Sources: CIS, progress nots, plan of care, vital signs records. interview with staff members.
[502]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 26 (4) (a)

The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home, completed a nutritional assessment for a resident on admission and whenever there was a significant change in the resident's health condition.

Rationale and Summary
The resident started having poor fluid intake on day four and poor food intake on day six after admission. From day nine until day sixteen the resident was refusing to eat.

Review of the plan of care did not identify any focus, goal or interventions related to nutrition and hydration.

The assessment record in the home's documentation system Point Click Care (PCC) did not show a completed nutritional assessment.

The registered dietitian (RD) stated that they visited the home on day eleven after the resident's admission.

The RD stated that they had not assessed the resident because the resident's weight and height, which should have been taken on the first day of admission, were not available. They did not want to start an assessment that they would not have completed. The resident was discharged before their next visit in the home.

Sources: Plan of care, progress notes, PCC's assessment record, look back report, and staff members interviews.

[502]

WRITTEN NOTIFICATION: Nutrition Care and Hydration Programs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 68 (2) (a)

The licensee has failed to comply with an identified care equipment Replacement Policy #RC-18-01-10 developed and implemented, in consultation with a registered dietitian and related to nutrition care and dietary services and hydration.

The identified care equipment Replacement policy under Appendix 1 - Inadvertent Removal of the care equipment, states that the equipment will only be changed/replaced by the Nurse Practitioner or Attending Physician. The alternate care equipment may only be inserted by a nurse who has received a training and is competent to perform the procedure.

Specifically, a registered nurse had not complied with the policy “Appendix 1 - Inadvertent Removal of an identified care equipment”, dated January 2022, which was included in the licensee’s Nutrition and Hydration Program.

Rationale and Summary:
A day in October 2022, the resident’s identified care equipment fell out during care. The DOC told staff to transfer the resident to hospital for replacement procedure. A registered nursing staff contacted the attending physician to obtain a verbal physician order to insert alternate equipment until the resident could be transferred to the hospital for replacement procedure.

The registered nursing staff member completed a replacement procedure with alternate equipment and gave directions to home’s other registered nursing staff members to feed and administer medication via alternate equipment. The alternate equipment fell out one day after the registered staff inserted the alternate equipment.

Two days later, the resident's health condition deteriorated, and the resident was transferred to hospital.

The DOC indicated that the home’s expectation was to have the attending physician, the NP or a competent Nurse who had received a training insert the alternate piece of equipment. The DOC indicated the registered staff had not received a training to insert the alternate piece of equipment and

should have not inserted nor allowed the resident to be fed unless the placement was checked in hospital.

As such, the registered nursing staff put the resident at high risk of complication when the policy was not complied with.

Sources: Appendix 1 - Inadvertent Removal of an identified care equipment, progress notes. Interview with a staff member.
[502]

WRITTEN NOTIFICATION: Nutrition care and hydration programs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 68 (2) (d)

The licensee has failed to comply with the policies and procedures related to a resident' s nutrition and hydration that include a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

The policy stated that Nurses/ Interdisciplinary team will (1) review intake records on daily basis; (2) complete a referral to the Registered Dietitian/designate, if the resident (a) consumed 50% or less from all meals for three consecutive days.

Specifically, staff did not comply with the policy “Food and Fluid Intake Monitoring”, dated January 2022, which were included in the licensee’s Nutrition and Hydration Program.

Rationale and Summary
The resident started having poor fluid intake on day four and poor food intake on day six after admission. From day nine until day sixteen the resident was refusing to eat.

On two occasions during that period staff documented that the resident had less than 50 percent (%) of the meals and a referral to the Registered Dietitian (RD) was required as per home’s policy. Review of the resident health record did not identify a completed Referral to Registered Dietitian.

A staff member indicated that they were not aware that the resident had poor food and fluid intake as they had not received the referral from nursing staff.

By not following the licensee’s Nutrition and Hydration policy, the RD had not assessed the resident’s

nutritional needs, this contributed to the deterioration of the resident's health condition.

Sources: Food and Fluid Intake Monitoring Policy, progress notes, look back report, and staff interview. [502]

WRITTEN NOTIFICATION: Plan of Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident.

Rationale and Summary:
A resident's progress notes indicated that the resident has an identified infection. The notes indicated that the resident was sent to the hospital for further assessment related to a new altered skin integrity.

The resident's care plan indicated that the resident had an identified infection in September 2022. The medication Administration System (MAR) indicated that the resident was prescribed a medication for the infection. The resident's progress notes nor the resident's MAR for September 2022, indicated that the resident had a treatment to the identified infection. There were no interventions documented in the resident's care plan related to the prescribed medication, and the assessment for that infection.

The RAI-MDS coordinator stated that there were no interventions documented in resident's care plan related to the resident's identified infection.

As such, the resident was at risk of not having consistency in their care as their written plan of care did set out clear directions to staff and others who provided direct care to them

Sources: Resident's health care records and interview with the RAI-MDS Coordinator. [211]

WRITTEN NOTIFICATION: Plan of Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of the care set out in the plan of care was

documented.

A) Rationale and Summary
In October 2022, a resident displayed behaviours toward a co-resident, which resulted in an injury to the co-resident.

A day in October 2022, a Dementia Observation System (DOS) monitoring tool assessment was initiated, and staff members were to monitor and document on the co-resident's behaviours every 30 minutes for five days.

Review of the completed DOS monitoring tool and the DOC interview indicated that staff members had not consistently documented the resident's behaviours for the five days in October 2022.

By not documenting the resident's behaviours, staff were not aware of the effectiveness of the interventions in place.

Sources: Resident health record, DOS monitoring tool staff members interviews.
[502]

B) Rationale and Summary
A resident's progress notes indicated that the resident was sent to the hospital by the DOC a day in January 2022. There was no documentation in the resident's health care record as to the resident's health status, nor a reason for the transfer to hospital.

The DOC and Executive Director (ED) indicated that the documentation was completed by the physician, which outlined the hospital discharge plan. There was no information regarding the resident's health status or care provided by staff prior to sending the resident to hospital.

As such staff members were not aware of the effectiveness of interventions for the resident prior to transferring the resident to the hospital.

Sources: Resident's health care record and staff interview.
[502]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that the licensee's written policy to promote zero tolerance of abuse of residents was complied with.

As per, O. Reg 246/22 s. 2 (1) physical abuse means:
a) the use of physical force by anyone other than a resident that causes physical injury or pain,
b) Administering a drug for an inappropriate purpose.

Rationale and Summary:
Specifically, the licensee's policy and procedures titled "Zero Tolerance of Resident Abuse and Neglect Program" #RC-02-01-01 reviewed in January 2022 indicated:
-Immediately initiate an investigation of the alleged, potential, suspected or witnessed abuse.
-Ensure the safety of and provide support to the abuse victim (s) through completion of full assessment, a determination of resident needs and a documented plan to meet those needs.
-Contact the physician/Nurse Practitioner for further assessment if required and communicate the status of the resident.
-Staff must complete an internal incident report and notify their supervisor. During after-hours the nurse on site would then call the manager on-call or general manager/designate immediately upon suspecting or becoming aware of abuse of neglect of a resident.
-In cases of physical abuse, it is imperative to preserve potential evidence as the incident may result in criminal charges and ensure that consent is obtained to take pictures of any injuries or evidence and accurate detailed description of injuries, condition is documented in the resident's chart.
-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.
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.

A Resident's progress notes showed that four staff members became aware of the resident's allegation that they had received improper treatment care from a staff member. One staff documented that the resident was told to inform a management staff since these were serious allegations of staff to resident

improper care.

The second management staff stated that the email sent to the corporate staff members 2 days after the resident's allegation was the investigation report. The second management staff confirmed that no report of the alleged incident of improper care or treatment was sent to the Director, when staff members became aware of the incident.

As such, the licensee did not:
-use their policy and procedures titled "Zero Tolerance of Resident Abuse and Neglect Program" to immediately investigate, complete an internal incident report and notify their manager on-call when the resident's stated that the staff member has provided improper care, and
-immediately informed the Director when the licensee had reasonable grounds to suspect that the resident received improper or incompetent treatment or care that resulted in harm or a risk of harm to the resident.

Sources: A resident's progress notes, policy, email and interviews with staff members.
[211]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to ensure that a person who has reasonable grounds to suspect that, improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident has occurred or may occur, immediately report the suspicion and the information upon which it is based to the Director.

Rational and Summary
A day in March 2023, a resident was scheduled for an identified morning care. At noon, a staff member started preparing the resident for their care and walked away leaving the resident wearing a continence care product, uncovered, without a blanket, the bed was at the highest position and the door was closed. The DOC was made aware of this incident of improper care of a resident by another staff member.

The DOC indicated that they had initiated a report to the Director but had not submitted until 8 days

after the incident.

As such, an incident of alleged improper care was not immediately reported to the Director.

Sources: CIS report and DOC interview.
[502]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who has reasonable grounds to suspect that, 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, immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary
A day October 2022, a resident displayed physical behaviours toward co-resident with identified objects, resulting in altered skin integrity and an injury. This incident was brought to the DOC's attention.
The DOC indicated that they had initiated a report to the Director but had not submitted the report until five days after the incident.

As such, an incident of alleged resident to resident abuse was not immediately reported to the Director.

Sources: CIS report and staff member interview.
[502]

WRITTEN NOTIFICATION: Further Training Needs

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (6)

The licensee has failed to ensure that the further training needed by staff members was assessed regularly, and the further training needs identified by the assessments were addressed in accordance with the requirements provided for in the regulations.

A) Rationale and Summary
A day in January 2022, a staff member was reported not to provide proper care to a resident. The DOC met with the staff member as per the home's internal administrative processes. The staff was not required to complete the re-education as part of the HR/investigation process.

A day March 2023, the staff member was reported to be distracted and disorganized, they left a resident half-naked without providing care, on a bed at the highest position.

Another staff member reported that the staff member went to the resident's room, started preparing them for a specified care, suddenly ran out of the room and did not provide care to the resident.

The DOC indicated that internal administrative procedures were implemented with the staff member but these did not identify and include training needs related to Prevention of Abuse and Neglect.

As such the resident was at risk when staff member's training needs were not address after the first incident.

Sources: Home's investigation and internal documentation. Staff members interviews.
[502]

B) Rationale and Summary
Documentation showed that a second staff member had provided improper care or forgot to provide care to at least three residents over a period of several months. A day in December 2022, the staff member left a resident in bed with soiled continence care product.

The DOC stated that the staff member was offered additional training on how to care for the residents, but they did not identify, and address training need related to abuse and neglect in accordance with the requirements provided for in the regulations.
The DOC indicated that they followed the home's internal administrative processes but had not addressed training need related to abuse and neglect in accordance with the requirements provided for in the regulations.

As such the residents were at risk when staff member's training needs were not addressed after five incidents since their last abuse and neglect training in March 2022.

Sources: Home's investigation and internal documentation. Staff members interviews.
[502]

WRITTEN NOTIFICATION: Binding on licensees

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to comply with the Minister's Directive to follow the Public Health Ontario as of July 16, 2021 "Coronavirus Disease 2019 (COVID-19), Key Element of Environmental Cleaning in Healthcare Settings".

In accordance with the Public Health Ontario as of July 16, 2021, "Coronavirus Disease 2019 (COVID-19), Key Element of Environmental Cleaning in Healthcare Settings" indicated to clean and disinfect high touch or frequently touched surfaces at least once per day and more frequently in outbreak areas. Examples of these surfaces include doorknobs, call bells, bedrails, light switches, toilet handles, handrails, and keypads.

Rationale and Summary:
During the inspection, staff reported that the enhanced environmental cleaning and disinfection for frequently touched surfaces had not been performed when the home was in a covid-19 outbreak.

A staff member stated that the frequently touched contact surfaces were cleaned and disinfected at least once daily, even during a covid-19 outbreak.

The "High Touch Surfaces" in North Wing were cleaned and disinfected once during day shift. The "high Touch Surfaces" in the East Wing were cleaned and disinfected once during evening shift. Occasionally, some areas of high touch surfaces such as the corridor railing were cleaned and disinfected more than once a day during the evening shift when housekeeping staff observed a resident walking in the corridor holding the railing.

The Environmental Manager Services (EMS) stated that the frequently touched contact surfaces were cleaned and disinfected once per day during covid-19 outbreaks in the home. The EMS stated that they should have had one additional housekeeping staff in each wing's unit during the day and the evening shifts to clean and disinfect more frequently the high touched surfaces in the outbreak areas.

As such, the residents were at risk of cross-contamination when the home had not cleaned and disinfected the high touched surfaces in the outbreak areas more than once daily.

Sources: The Minister's Directive: Covid-19 response measure for long-term care homes, effective August 30, 2022, the Public Health Ontario as of July 16, 2021, titled "Coronavirus Disease 2019 (COVID-19), Key Elements of Environmental Cleaning in Healthcare Settings" and interviews staff members. [211]

WRITTEN NOTIFICATION: Skin and wound care

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

The licensee has failed to ensure that a resident, at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

Rationale and Summary:
A day in September 2022, a resident's progress notes indicated that the resident had altered skin integrity, was transferred to the hospital for further assessment and returned the same day. On that date, the electronic "Skin-Head to Toe Skin Assessment" was not completed by a staff member upon the resident return from hospital.

The RAI/MDS Coordinator confirmed that the "Skin-Head to Toe Skin Assessment" was not completed by the staff member when the resident returned from the hospital.

As such, the resident did not received a head-to-toe skin assessment when the resident returned from the hospital.

Sources: Resident's health care records and interview with the RAI-MDS Coordinator.
[211]

WRITTEN NOTIFICATION: Skin and wound care

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iii)

The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds, was assessed by a registered dietitian who was 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.

Rationale and Summary:
A day in September 2022, a resident's progress notes indicated that the resident had an altered skin integrity. Ten (10) days later the resident had a new or worsening altered skin integrity.

The RD stated that a referral was not received when the resident first exhibited altered skin integrity.

As such, by failing to refer the resident to the RD when the resident exhibited altered skin integrity, there was a risk that the RD would not have been able to assess the resident's nutritional needs in regards to their altered skin integrity.

Sources: Resident's health care records and interview with the Registered Dietitian.
[211]

WRITTEN NOTIFICATION: Skin and wound care

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

The licensee has failed to ensure that a resident, exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds, was reassessed at least weekly by member of the registered nursing staff, if clinically indicated.

Rationale and Summary:

In September 2022, a resident's progress notes indicated that the resident had two sites of altered skin integrity.

The licensee's electronic clinically appropriate assessment tools for skin and wound assessment was not used weekly to reassess the resident's altered skin integrity for three weeks until the wounds were healed.

As such, the resident who was exhibiting altered skin integrity was not reassess at least weekly by a member of the registered nursing staff.

Sources: Resident's health care records and interview with the Resident Assessment Instrument/Minimum Data Set (RAI/MDS) Coordinator. [211]

WRITTEN NOTIFICATION: Altercations and Other Interactions Between Residents

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between 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.

Rationale and Summary
Review of a resident's progress notes indicated that for three months in 2023, the resident displayed verbal and physical behaviours towards cognitively impaired residents including a co-resident. The resident used their mobility device to intimidate cognitively impaired residents. A day in October 2022, the attending physician suggested some interventions to the resident regarding their verbal communication with others.

In October 2022, the co-resident displayed physical behaviours toward the resident, resulting in injury.

The resident ambulated independently and displayed physical and verbal behaviours. Different interventions were outlined in the plan of care to address the resident's behaviours. The progress notes and Behavioural Support Ontario (BSO) interview indicated that the interventions were not unsuccessful.

The co-resident was cognitively impaired. The interventions to address their behaviours was via verbal interventions and safety check every hour and as needed (prn).

A staff member indicated that the resident's behaviours started in June 2022, when the co-resident moved in the same room. The resident was verbally abusive toward the co-resident, which triggered the co-resident's behaviours. The co-resident was moved to another room, but both residents continued to share the same washroom. Both residents continued to display verbal behaviours each time both residents saw each other.
A day in October 2022, the co-resident's behaviours escalated to physical altercation towards the resident resulting in injury. A staff member indicated that interventions were not effective and

Psychogeriatric became involved in the resident's care due to safety concern.

The DOC indicated that the resident was not compliant to the interventions in place. They were waiting for a room to become available to move the co-resident away from the resident, which took a long time to achieve.

By leaving both residents in a proximity of each other, and not taking steps to minimize the risk of altercations and potentially harmful interactions between both residents, the resident sustained injury.

Sources: Residents' health records. BSO and other relevant staff members interviews.
[502]

WRITTEN NOTIFICATION: Integrating restorative care into programs

NC #017 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 63 (b)

The licensee has failed to ensure that four residents restorative care approaches related to physiotherapy were coordinated to maintain or improve their functional and cognitive capacities in all aspects of daily living, their extent of their abilities.

Rationale and Summary:
An identified outbreak was declared in the home for about three weeks.

The first resident's progress notes indicated that the resident was under isolation precaution a day in April 2023, related to an identified infection. The resident's current care plan indicated that they required two different types of physiotherapy interventions, two to three times a week.

The second resident's progress notes indicated that the resident's test result negative to the identified infection in April 2023. However, the resident was placed in isolation precaution two days later, as the co-resident was positive to the identified infection. The resident's current care plan indicated that they required physiotherapy services, three times a week.

The third resident's progress notes indicated that the resident was placed in isolation precaution in April 2023, as their test result was positive to the identified infection. The resident's current care plan indicated that they required physiotherapy services, two to three times a week.

The fourth resident's progress notes indicated that the resident was placed in isolation precaution in April 2023, as they were in close contact with a person who the result was positive. The resident's health care records indicated that they required physiotherapy services two to three times a week.

The Physiotherapist Assistance (PTA) stated the residents who tested positive for covid-19 and those who shared the same room regardless of their negative result were not to receive the physiotherapy services. The four residents had not received physiotherapy services since they were placed in isolation precaution.
The physiotherapist confirmed that the PTA was not allowed to provide physiotherapy services to residents with the identified infection.

The Executive Director acknowledged physiotherapy should have provided care to all residents wearing proper PPE as per Achieva Health's physiotherapist, Chief Executive Officer (CEO) email.

As residents four resident's restorative care approaches related to physiotherapy were not provided as specified in their plan, the residents were at risk for physical deconditioning as they had not received physiotherapy services since the home was declared in an identified outbreak.

Sources: Residents' health care records, Achieva Health's email and interviews with Physiotherapist, Physiotherapist Assistance and Executive Director. [211]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #018 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (c)

The licensee has failed to comply with the licensee policy and procedures "Food and Fluid intake Monitoring" in the implementation of interventions to meet a resident's daily food and fluids requirement, in consultation with the Registered Dietitian to mitigate and manage nutritional care and hydration risks.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to the implement interventions to mitigate and manage those risks.

A) Rationale and Summary:
Specifically, staff did not comply with the policy RC-18-01-01 titled "Food and Fluid intake monitoring" dated January 2022 that indicated the following:

Fluid Intake Monitoring:
1. Review fluid intake records daily and compared to individualized fluid target, as assessed by the Registered Dietitian/designate.
2. If the resident consumes less than their individualized fluid target level for three (3) consecutive days, the nurse must take into account additional fluids taken with medication, supplements and other fluids not provided at meals or snack times.
3. If after considering additional fluid intake, the resident still has not met their individualized fluid target for three (3) consecutive days, the nurse must complete a Nursing Hydration Assessment.
4. If the hydration assessment indicates signs and symptoms of dehydration, immediately implement interventions to increase fluid intake based on the needs and preference of the resident, in collaboration with the Dietary Department Lead.
5. Refer to the Registered Dietician/designate if signs or symptoms of dehydration are present.

A resident's "Nutrition-Registered Dietitian Assessment" for September 2022, indicated that the estimated fluid need was 1500 milliliter (ml) per day.

The resident's health care records titled "Total Fluid and Food" 10 days period in September 2022, indicated that the resident total fluid intake was below 1000 ml per day. The resident's total fluid intake for one week in October 2022 was between 180 ml to 720 ml per day.

The DOC stated that each resident's fluid intake consumption was assessed by a Registered Nursing Staff on Friday night shift. The DOC stated that the resident had a pitcher of water at their bedside and was drinking a lot of water during the day. However, the staff members were not documenting the amount of water consumed by the resident and they needed to be reminded frequently.

The RD stated that the staff members needed to document not only the fluid intake consumed during meal and snack times, but all other fluids consumed during the day. A staff member needed to review fluid intake records daily and compare to the individualized fluid target. If a resident did not consume their individualized fluid target level for three consecutive days, the Registered Nursing Staff needed to follow their policy related to food and fluid intake monitoring. The RD stated that a Nursing Hydration Assessment nor a referral was sent to the RD for the period mentioned above, when the resident's fluid intake for three consecutive days was below the resident requirement.

Sources: A resident's health care records and interviews with the Registered Dietitian
[211]

B) Rationale and Summary:
Specifically, staff did not comply with the policy RC-18-01-01 titled "Food and Fluid intake monitoring"

dated January 2022 that indicated to complete a referral to the Registered Dietitian/designate if the resident consumed 50% or less from all meals for three (3) or more days.

A Resident's progress notes for one week period in 2022, indicated under an alert note that "less than 50 percent (%) meal intake was recorded for 3 days and that the policy required a referral to the Registered Dietitian (RD)".

The RD stated that a referral should have had been sent by the Registered Nursing Staff to assess the resident's food intakes when the resident's progress notes "pop-up" indicated that the resident had eaten less than 50 % in the last 3 days.

Consequently, the resident's nutritional and fluid intake needs was put at risk when the licensee did not comply with their policy "Food and Fluid Intake Monitoring" that indicated:
- to review fluid intake records daily and compared to individualized fluid target, as assessed by the Registered Dietitian/designate.
- to complete a RD referral if a resident consumed 50% or less of all their meals for three or more days.

Sources: A resident's health care records and interviews with the Registered Dietitian and the DOC. [211]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #019 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)

The licensee has failed to comply with the policy and procedures related to a resident's weight monitoring system to measure the resident's weight monthly.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to implement the a weight monitoring system.

Specifically, staff did not comply with the licensee policy "Height and Weight Monitoring" dated January 2022, indicating that all residents will be weighted and monitored at least once a month and whenever a significant change occurs that can affect the resident's weight. The procedures indicated to compare the previous month's weight and any weight with a 2.5 Kilogram (Kg) difference from the previous month requires a re-weigh to ensure accuracy. The nurse will direct care staff to re-weigh the resident.

Rationale and Summary:
A resident recorded weight indicated that the resident's weight was taken in July 2022, and there was no documentation of the resident's weight in August 2022. The RD indicated that the resident's weight documentation was incorrect in September and October 2022.

The resident's progress notes documentation indicated in August 2022, that they were unable to take the resident's weight. In September 2022, two requests were made to re-weigh the resident to confirm the accuracy of September weight.

The DOC stated that the resident was frequently refusing care. However, if they were unable to take the resident's weight, they should had tried later or informed a staff member on the next shift.
The RD stated since the weight was not taken in August 2022 and the weight in September and October 2022 was not accurate, it was difficult to assess if the resident had lost weigh because of dehydration or the resident was eating well.

Consequently, the RD was unable to assess the resident's dietary health status accurately as the resident's weight was not taken in August 2022 and was re-weight as requested by the RD for September and October 2022.

Sources: Resident's health care records and interviews with the DOC and the RD. [211]

COMPLIANCE ORDER CO #001 Prevention of Abuse and Neglect

NC #020 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure that residents are protected from neglect.

Specifically, the licensee shall:
A- Provide training for all Personal Support Workers on the home's policy to promote zero tolerance neglect of residents. As part of this training, provide and discuss examples of how not providing care as per a resident's plan of care could be considered neglect and how this can be prevented.

B-Keep a documented record of the training, including the date the training was completed, who provided the training and all PSW staff who attended.

Grounds

The licensee has failed to ensure that the residents were not neglected by the staff.

As per O. Reg. 246/22 s. 7. “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) Rationale and Summary
The first resident’s plan of care indicated that the resident prefers care preference.

A day in January 2022, the resident was incontinent multiples times and the staff provided care. The resident reported to the DOC that the staff member had not cared for them properly; this was confirmed by the DOC during their investigation.

A day in March 2023, unit staff members noted that the staff member was distracted and disorganized. Concerned for the safety of the residents the staff member was providing care to, the unit staff members brought their concerns to the DOC’s attention. The DOC indicated that they met with the staff member.

After meeting with the DOC, a second staff member reminded the staff member that the resident had not received care and required a specified care. The staff member went to the resident’s room, started preparing for the resident’s care. Suddenly the second staff member observed the staff coming out of the resident’s room upset, they walked away and closed the resident's bedroom door.

A second staff member went immediately in the resident room and found the resident alone, wearing only a continence care product, without a blanket, and the bed was at a highest position. The resident was not injured, but was upset by the situation, and emotional support was provided to the resident.

As such the resident was neglected by the staff member.

Sources: Plan of care, home’s investigation, staff members interviews.
[502]

B) Rationale and Summary
A day in December 2022, a resident was found in bed with soiled continence care product. The resident had not received an identified care or meal. The last documented provision of continence care was a day before.

The staff member was expected to meet the DOC prior to the end of the shift to ensure all tasks were

completed as assigned. On the day of the incident, the staff member forgot to provide continence care to the resident. Other staff members working in the unit did not notice that the resident was in bed with soiled continence care product until the DOC checked at the end of the staff member's shift.

The DOC stated that they were completing random spot checks to ensure care was provided to residents. The DOC acknowledged that leaving the resident soiled without providing continence care was neglect.

As such the resident was neglected by the staff member.

Sources: The home’s investigation, staff personal file, staff members interviews.
[502]

This order must be complied with by July 30, 2023

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.