Ontario

Ministry of Long-Term Care	Ministère des Soins de longue durée
Inspection Report under the Long-Term Care Homes Act, 2007	Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 3, 2020	2020_633577_0009	003861-20, 004461-20	Complaint

Licensee/Titulaire de permis

CVH (No. 9) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Southbridge Roseview
99 Shuniah Street THUNDER BAY ON P7A 2Z2

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

DEBBIE WARPULA (577)

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 15-19 and 22, 2020.

Critical Incident System (CIS) Inspection #2020_633577_0010 and Follow Up (FU) Inspection #2020_633577_0011 was conducted concurrently with this CO Inspection.

The following intakes were inspected during this Complaint (CO) Inspection:
- Two intakes related to staff to resident neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Resident Assessment Instrument (RAI) Coordinator, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and a family member.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions and resident to resident interactions, reviewed training records, employee files, relevant health care records, and various policies and procedures.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
2 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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff involved in the different aspects of care collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A Critical Incident System (CIS) report was received by the Director on an identified date, related to staff to resident neglect. The CIS report indicated a complaint was received by the home from resident #001's family member on an identified date. The complaint alleged that PSW #100 had left resident #001 in a particular position in their specific mobility aid in a particular area in their room, specific items were not within reach of the resident.

A review of the home's investigation notes found that PSW #100 had transferred resident #001 off the toilet and into their specific mobility aid as a specific level of assistance; the family member had indicated that they had previously requested that resident #001 be a particular level of assistance and questioned why the PSW performed the transfer as a specific level of assistance.

A review of resident #001's plan of care at the time of the incident found that the resident required a particular level of assistance with all transfers, other than into bed; and required particular level of assistance with a particular care activity with one staff.

A review of resident #001's most recent Safe Lift and Transfer Assessment assessments (SALT), completed quarterly over a specified time period, indicated that resident #001

was assessed as a particular transfer assist.

A review of resident #001’s most recent Physiotherapy assessments, completed quarterly , over a specified time period, indicated that resident #001 was assessed as a particular transfer assist.

During an interview with Physiotherapist Assistant (PTA) #101 and Physiotherapist (PT) #102, together with Inspector #577, reviewed the previous physiotherapy assessments. They indicated that resident #001 was a particular assist for transfers, due to a specific medical condition; the resident would not have been safe as a different particular transfer. They further reported that staff should have been following the PT transfer assessments for safety.

During an interview with PSW #100, they reported to Inspector that when they were transferring resident #001 off the toilet by themselves, the resident had a specific incident and they needed to call for assistance.

During an interview with PSW #103, they reported that they were part of the Safe Lift Team, and they received referrals for SALT assessments. They further reported that staff should be following the SALT assessments, not PT assessments, because they are "Southbridge" and Physiotherapy was an outside provider.

During an interview with ADOC #104, they reported that staff should be following the SALT assessments for direction on transfers, not the PT assessments. They indicated that that the Safe Lift Team takes precedence over the PT assessments. Inspector #577 indicated that the PT assessments consistently indicated that the resident was a specific transfer. ADOC #104 confirmed that there was a lack of collaboration between PT and SALT assessments concerning resident transfer status.

During an interview with the DOC, they reported that that the Safe Lift Team gives the final direction on the resident transfer status; physiotherapy's role was to promote and improve the resident’s physical status, treat orthopedic concerns, referrals and weren’t available full time in order to be giving input on resident transfers; further, staff did not need to follow PT’s direction on transfers, except for post op hip fractures. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the care set out in resident’s plan of care was provided to the resident as specified in the plan.

A Critical Incident System (CIS) report was received by the Director on an identified date, related to staff to resident neglect. The CIS report indicated a complaint was received by the home from resident #001's family member on an identified date. The complaint alleged that PSW #100 had left resident #001 in a particular position in their specific mobility aid in a particular area in their room, specific items were not within reach of the resident.

A review of the home's policy, "Plan of Care – RC-05-01-01", revised June 2020, indicated that the plan of care served as a communication tool that promoted safe and effective resident care which identified immediate risks to safety and care needed to allow the care team to have implemented strategies to midigate risk and provide appropriate care; the plan of care was defined as a series of documents that provided information to the care team and included the care plan, assessments completed, progress notes, etc.

A review of resident #001's plan of care at the time of the incident found that the resident required a specific mobility aid as needed; and staff were to have ensured that the resident had specific items within reach in their room.

A review of resident #001's most recent Physiotherapy assessments, completed over a specified time period, indicated that resident #001 required a specific mobility aid for long distance mobility.

During an interview with PSW #100, they advised Inspector #577 that on an identified date, they had transferred resident #001 from the toilet into their specific mobility aid, in a particular position, as their co-worker advised them so that the resident wouldn't engage in a certain position.

During an interview with the ADOC #104, they advised Inspector #577 that resident #001's specific mobility aid was not to be in a particular position and was used for resident transport, and PSW #100 had not followed the resident's care plan. [s. 6. (7)]

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 staff involved in the different aspects of care collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and to ensure that the care set out in resident's plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraining of a resident by a physical device was included in a resident's plan of care only if all of the following were satisfied: a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

A Critical Incident System (CIS) report was received by the Director on an identified date, related to staff to resident neglect. The CIS report indicated a complaint was received by the home from resident #001's family member on an identified date. The complaint alleged that PSW #100 had left resident #001 in a particular position in their specific

mobility aid in a particular area in their room.

A review of the home's policy, "Least Restraints - RC-22-01-01", revised December 2019, indicated that all residents had the right to live in a safe environment, free from restraints; staff were to have obtained a physician's order for the restraint and consent was to be obtained from the resident, where possible, or the Power of Attorney (POA); restraints were to be implemented only as per the restraint order and upon consent; and the tilt feature on a wheelchair was considered a physical restraint.

A review of resident #001's plan of care at the time of the incident found that the resident required a specific mobility aid for mobility as needed.

A review of resident #001's Physiotherapy assessment, on an identified date, indicated that resident #001 required a specific mobility aid for long distance mobility.

During a record review of resident #001's health records, Inspector #577 could not locate a physician order directing staff to reposition resident #001's specific mobility aid.

A review of the home's investigation notes found that PSW #100 had reported that resident #001's specific mobility aid was to be used for transport only, and on an identified date, they left the resident #001 in a particular position in their specific mobility aid in their room.

During an interview with PSW #100, they advised Inspector #577 that on an identified date, they had transferred resident #001 from the toilet into their specific mobility aid and in a particular position, as their co-worker advised them so that the resident wouldn't engage in a certain position. They further advised that the resident would not have been able to get out of their specific mobility aid.

During an interview with the ADOC #104, they advised Inspector #577 that resident #001's specific mobility aid was not to be in a particular position and was to be used for resident transport; they confirmed that there wasn't an order to reposition the mobility aid and advised the Inspector that resident #001 wasn't being restrained, and considered the specified feature a PASD, and was being positioned. Inspector #577 referred the ADOC to the Restraint policy which indicated that the specified feature on a specific mobility aid was considered a physical restraint. ADOC #104 reported that it could go either way, a restraint or a PASD. [s. 31. (2) 4.]

2. The licensee failed to ensure that the restraining of a resident by a physical device was included in a resident’s plan of care only if all of the following were satisfied: the restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

A Critical Incident System (CIS) report was received by the Director on an identified date, related to staff to resident neglect. The CIS report indicated a complaint was received by the home from resident #001’s family member on an identified date. The complaint alleged that PSW #100 had left resident #001 in a particular position in their specific mobility aid in a particular area in their room.

A review of the home's policy, "Least Restraints - RC-22-01-01", revised December 2019, indicated that the specified feature on a mobility aid was considered a physical restraint; staff were to have obtained a consent for the restraint and was to be obtained from the resident, where possible, or the Power of Attorney (POA).

A review of resident #001’s plan of care at the time of the incident found that the resident required a mobility aid as needed.

A review of resident #001’s Physiotherapy assessment, on an identified date, indicated that resident #001 required a specific mobility aid for long distance mobility.

During a record review of resident #001’s health records, Inspector #577 could not locate a consent from the resident or POA to reposition resident #001’s specific mobility aid.

A review of the home’s investigation notes found that PSW #100 had reported that resident #001’s specific mobility aid was to be used for transport only, and on an identified date, they left the resident in a particular position in their specific mobility aid in a particular area in their room.

During an interview with PSW #100, they advised Inspector #577 that on an identified date, they had transferred resident #001 from the toilet into their specific mobility aid and into a particular position, as their co-worked advised them so that the resident wouldn’t engage in a certain position. They further advised that the resident would not have been able to get out of their specific mobility aid.

During an interview with the ADOC #104, they advised Inspector #577 that resident #001’s specific mobility aid was not to be repositioned and was used for resident

transport, and there wasn’t an order to reposition the mobility aid. [s. 31. (2) 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 the restraining of a resident by a physical device is included in a resident’s plan of care only if all of the following are satisfied: a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if the use of the PASD has been approved by a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulations.

During observations throughout inspection, Inspector #577 noted resident #002 to be in a particular position in their specific mobility aid at varying times.

A review of the home's policy, "Personal Assistance Service Devices (PASDs) - RC-22-

-05", revised December 2019, indicated that staff were to obtain approval for the PASD from a physician, registered staff, Occupational Therapist or Physiotherapist. Staff were to monitor, check and reposition residents with a PASD every two hours, and more often as necessary, for safety and comfort.

During a record review of resident #002's health records, Inspector #577 found an order on an identified date, for a specific device while in their mobility aid for increased risk for injury from repeated incidents from their mobility aid; the Inspector could not locate an order that directed staff to reposition resident #002's mobility aid.

During a record review, Inspector #577 found a "Least Restraint - Restraint Assessment", on an identified date, that indicated a specific device while in their wheelchair. The assessment indicated that resident #002 continuously engaged in a certain position in their mobility aid and had eight incidents since admission. The resident had at least six "near misses" that morning where staff had to reposition them in a specific way in their mobility aid. The resident was transferred into their specific mobility aid and continued to attempt to get out of the specific mobility aid; the specific apparatus was applied and an order and consent had been received.

During a record review, Inspector #577 found a "PASD assessment/reassessment", on an identified date, that indicated a specific mobility aid was used to aid in positioning, repositioning and mobility.

During a record review, Inspector #577 found a "Least Restraint - Personal Assistance Service Device (PASD) Assessment", on an identified date, that indicated the use of a specific apparatus with their specific mobility aid.

A review of the physiotherapy assessment on an identified date, indicated a specific mobility aid for mobility.

A review of resident #002's care plan indicated the following:
- resident used a specific mobility aid for mobility;
- resident required a specific device when up in their mobility aid to decrease risk of injury from specific incidents; and
- the PASD specific mobility aid assisted the resident with positioning needs and particular care needs and would be monitored at a minimum of every two hours for safety.

During an interview with RPN #105, they advised Inspector #577 that resident #002 had a specific device that was considered a restraint; they confirmed that the resident had a specific mobility aid and some staff repositioned the resident in their mobility aid; they reported there was a quarterly PASD assessment for the specific mobility aid and it was positioned for the purpose of particular care needs. They further advised that PSWs were to document every two hours for the specific device and for repositioning. They confirmed that there wasn't an order or consent for the specific mobility aid.

During a record review, Inspector #577 could not locate any documentation by PSWs related to PASD monitoring for the specific mobility aid.

During an interview with the DOC, they advised Inspector #577 that some staff do reposition resident #002's specific mobility aid and confirmed that there wasn't an order for a specific mobility aid [s. 33. (4) 3.]

2. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority has given that consent.

During observations throughout inspection, Inspector #577 noted resident #002 to be in a particular position in their specific mobility aid at varying times.

During a review of the home's policy, "Personal Assistance Service Devices (PASDs) - RC-22-01-05", revised December 2019, indicated that staff were required to obtain consent for a PASD from the resident, where possible, or the SDM; consents could be obtained by telephone but signed by the party giving consent.

During a record review of resident #002's health records, Inspector #577 found an order on an identified date, for a specific apparatus while in the specific mobility aid for increased risk for injury from repeated incidents from their mobility aid; the Inspector could not locate an order that directed staff to reposition resident #002's specific mobility aid.

A review of resident #002's care plan indicated the following:
- the resident used a specific mobility aid for mobility;
- the PASD mobility aid assisted the resident with particular care needs and would be

monitored at a minimum of every two hours for safety.

During a record review, Inspector #577 found a “PASD assessment/reassessment”, on an identified date, that indicated a specific mobility device was used to aid in particular care needs.

During an interview with RPN #105, they advised Inspector #577 that resident #002 had a specific mobility aid and some staff repositioned them in their mobility aid; they reported there was a quarterly PASD assessment for the specific mobility aid and it was positioned for the purpose of particular care needs. They further advised that there wasn’t a consent for the specific mobility aid.

In an interview with the DOC, they advised Inspector #577 that there wasn't an order for a specific mobility aid. [s. 33. (4) 4.]

Issued on this 29th day of July, 2020

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

Original report signed by the inspector.