

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

Rapport d'inspection prévue
sous la Loi de 2007 sur les foyers
de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de
longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 6, 2019	2019_655679_0029	010139-19	Complaint

Licensee/Titulaire de permis

CVH (No. 6) 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 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

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

MICHELLE BERARDI (679), DAVID SCHAEFER (757), KEARA CRONIN (759), LAUREN TENHUNEN (196), MELISSA HAMILTON (693), STEVEN NACCARATO (744)

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): November 4-8, 2019.

The following intake was inspected upon during this Complaint Inspection:

- One intake related to resident care concerns.

A Critical Incident Inspection (#2019_655679_0028) and a Follow Up Inspection (#2019_655679_0030) were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Acting Assistant Director of Care (AADOC), Registered Nurse (RN) Supervisor, Restorative Care Registered Practical Nurse (RPN), RNs, RPNs, Resident Assessment Instrument (RAI) Coordinator Backup, Housekeeping Aides, Personal Support Workers (PSWs), residents and families.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, complaint records, as well as relevant policies and procedures.

**The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Contenance Care and Bowel Management
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

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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. (9) The licensee shall ensure that the following are documented:**
- 1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
 - 2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
 - 3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

Findings/Faits saillants :

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

A complaint was submitted to the Director regarding care concerns for resident #002.

Inspector #693 reviewed resident #002's care plan. The care plan indicated that resident #002 required specified continence interventions.

Inspector #693 reviewed the home's complaints binder and identified a complaint made to the Director of Clinical Care (DOCC) on a specified date, which indicated that resident #002 was found in a specified state.

During an interview with PSW #115, they stated that for any resident who required a specified continence intervention, the continence care was documented in the resident's health care record. The PSW stated that the home started using a different documentation system in a specified month, and before continence routines were documented on a paper record.

Inspector #693 reviewed the home's investigation notes which contained copies of resident #002's continence record for a specified month. Inspector #693 identified that on a specified date, the continence record was left blank. In addition, the Inspector noted that on specified dates and times the continence record for resident #002 was left blank.

During an interview with PSW #106, they stated that they were responsible for caring for resident #002 on a specified shift. They stated that they knew that resident #002 required a specified continence intervention, but that they did not have time to implement the intervention as per the care plan. Together with the Inspector, PSW#106 reviewed resident #002's continence record for a specified month, and confirmed that on a specified date, they had not documented any continence care that was provided to resident #002.

During an interview with the Acting Assistant Director Of Care (AADOC), they stated that staff chart a resident's continence routine in the resident's health care record, as indicated by the resident's care plan. The AADOC stated that for resident #002 staff chart at a specified frequency if they provided the resident with continence assistance as per the resident's continence plan. The AADOC provided the Inspector with a specified report for resident #002 related to continence care.

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Inspector #693 reviewed the report as provided by the AADOC for resident #002, over a specified period, and identified that resident #002 was to be provided with a specified continence intervention. The corresponding documentation, by PSW staff was for the number of minutes spent on continence with the resident, and the documented times did not meet the times of the outlined intervention. In review of the specified report for resident #002, relating to continence, it could not be identified the number of times resident #002 was assisted with continence care over a specified period.

Inspector #693 reviewed the home's policy, titled, "Care Planning RC-05-01-01", last updated in June, 2019. The policy indicated that the plan of care served as a communication tool which enhanced the provision of individualized care, assisted in the provision of continuity of care as all team members were aware of the individualized plan, promoted safe and effective resident care and provided documentation.

Inspector #693 reviewed the home's policy, titled, "Daily Personal Care and Grooming, RC-06-01-01", last updated June 2019. The policy indicated that nurses and care staff were to document care provided to indicate care given or refused on the resident's medical record.

During an interview with the DOC, they stated that when a resident required a specified continence intervention, PSW staff were responsible to document in the resident's health care record as per the resident's individualized plan. The DOC stated that the home switched to a different documentation system in a specified month, and before that staff documented continence interventions on paper records for each individual resident. Together with the Inspector, the DOC reviewed resident #002's continence record, for a specific month, and confirmed that on a specified date, the continence record was left blank. The DOC further confirmed the additional times in which documentation was missing related to resident #002's continence intervention. The DOC confirmed that the documented reports and the task charting in the resident's health care record did not reflect the care as outlined in the plan of care for resident #002's continence routine, as they were not specific to if the resident was assisted as per the plan of care. The DOC called the Restorative RPN #120 to review the documentation for resident #002. The DOC stated that the Restorative RPN #120 was responsible for auditing documentation for a specified program. Restorative RPN #120 reviewed the documentation and confirmed that the documentation was not reflective of the continence care as outlined in the plan of care for resident #002. The DOC then called the RAI Coordinator Backup #121 to review the documentation for resident #002. The DOC, Restorative RPN #120 and the RAI Coordinator Backup #121 agreed and confirmed that the documentation for

resident #002 was not reflective of the continence care provided as outlined in the resident's plan of care, for a specified period. [s. 6. (9) 1.]

2. Inspector #693 reviewed resident #010's care plan which indicated that resident #010 required specified continence interventions.

During an interview with the RAI Coordinator Backup #121, they stated that resident #010 required a specified continence intervention, and that PSW staff charted the continence intervention in the resident's health care record. RAI Coordinator Backup #121 indicated that in addition, the PSWs would chart sleeping or refused on times that the resident was not assisted with continence.

Together with the Inspector, the RAI Coordinator Backup #121, Restorative RPN #120, and the DOC reviewed the documentation for resident #010 for a specified period. The DOC confirmed that the documentation was not reflective of the continence routine outlined in the plan of care for resident #010 as the documentation only showed the number of minutes staff spent assisting the resident and the level of assistance the resident needed with their continence, but did not show when the continence intervention was completed. In addition, the DOC identified that if staff had documented later in the day for care provided at an earlier time, the documentation would not reflect when the care was provided, and that on times that the continence intervention wasn't documented or was missed the staff had not always documented that the resident was asleep or refused the care; in conclusion for each day over a specified period, resident #010's provision of their individualized continence routine, was not documented in accordance with their plan of care. [s. 6. (9) 1.]

3. Inspector #693 reviewed resident #009's care plan, which indicated that they required specified continence interventions.

During an interview with the RAI Coordinator Backup #121, they stated that resident #009 required a specified continence intervention, and that PSW staff charted the continence intervention in the resident's health care record.

Together with the Inspector, the RAI Coordinator Backup #121, Restorative RPN #120, and the DOC reviewed the documentation for resident #009 over a specified period. The DOC confirmed that the documentation was not reflective of the continence routine outlined in the plan of care for resident #009, as the documentation only showed the number of minutes staff spent assisting the resident and the level of assistance the

resident needed with continence, but did not show when this resident was provided with the continence intervention. Further, if staff documented later in the day for care provided at an earlier time, the documentation would not reflect when the care was provided and that on times that continence care wasn't documented or was missed the staff had not always documented that the resident was asleep or refused the care. The DOC verified that on each day for a specified period, resident #009's provision of their individualized continence routine, was not documented in accordance with their plan of care. [s. 6. (9) 1.]

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 ensuring that the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

A complaint was submitted to the Director regarding care concerns for resident #002.

Inspector #693 reviewed resident #002's care plan. The care plan indicated that resident #002 required specified continence interventions.

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Inspector #693 reviewed the home's complaints binder and identified a complaint made to the DOCC on a specified date, which indicated that resident #002 was found in a specified state.

Inspector #693 reviewed the home's investigation notes, which contained photographs of resident #002. The photographs showed a specified continence intervention in a certain state. The notes indicated that the DOCC met with PSW #106 (who was assigned to assist resident #002), and that PSW #106 stated that they thought the resident had been provided care at an earlier time, and that they later assisted the resident at a specified time. PSW #106 stated they did not provide any care to the resident after a specified time for specified reasons. The investigation notes indicated that PSW #106 would receive discipline for not assisting resident #002 as per their care plan.

Inspector #693 reviewed a specific document. The document identified that resident #002's care plan indicated that they required a specified continence intervention. The document indicated that PSW #106 did not provide the continence intervention as outlined in the care plan.

During an interview with PSW #106, they stated that they were responsible for caring for resident #002 on a specified shift. They stated that they knew that resident #002 required a specified continence intervention, but that they did not have time to implement the intervention as per the care plan. The PSW stated that they checked the resident at a specified time, but they did not provide continence assistance to them at this time.

Inspector #693 reviewed, the home's policy, titled, "Continence Management Program, RC-14-01-01", last revised in August, 2018. The policy identified that care staff were to follow the resident's plan of care in relation to the continence management program. The "Scheduled Toileting and Bladder Retraining Routines" portion of the Continence program stated that staff were to toilet the resident at times based on the individual resident's pattern for residents on a scheduled toileting routine.

During an interview with the DOC, they stated that on a specified shift resident #002's care plan relating to continence was not implemented because the resident was only assisted with continence a specified amount of times, and should have received assistance as per their plan of care relating to continence. The DOC stated that although PSW #106 did state that they checked the resident, this was still not following the continence care plan as the resident was not provided with assistance as per their plan of care. [s. 51. (2) (b)]

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 ensuring that each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

- 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
- 4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
- 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

Findings/Faits saillants :

- 1. The licensee has failed to ensure that a person who had reasonable grounds to suspect improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident had occurred, or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.**

A complaint was submitted to the Director regarding care concerns for resident #002.

Inspector #693 reviewed resident #002's care plan. The care plan indicated that resident #002 required specified continence interventions.

Inspector #693 reviewed the home's complaints binder and identified a complaint made to the DOCC on a specified date, which indicated that resident #002 was found in a specified state.

Inspector #693 reviewed the home's investigation notes, which contained photographs of resident #002. The photographs showed a specified continence intervention in a certain state. The notes indicated that the DOCC met with PSW #106 (who was assigned to assist resident #002), and that PSW #106 stated that they thought the resident had been provided care at an earlier time, and that they later assisted the resident at a specified time. PSW #106 stated they did not provide any care to the resident after a specified time for specified reasons. The investigation notes indicated that PSW #106 would receive discipline for not assisting resident #002 as per their care plan.

Inspector #693 reviewed a specific document. The document identified that resident #002's care plan indicated that they required a specified continence intervention. The letter indicated that PSW #106 did not provide the continence intervention as outlined in the care plan. See WN #2 for further details.

During an interview with PSW #106, they stated that they were responsible for caring for resident #002 on a specified shift. They stated that they knew that resident #002 required a specified continence intervention, but that they did not have time to implement the intervention as per the care plan. The PSW stated that they checked the resident at a specified time, but they did not provide continence assistance to them at this time.

Inspector #693 reviewed the home's policy, titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting, RC-02-01-01", last updated in June 2019. The policy indicated that in Ontario, anyone who suspected or witnessed incompetent care or treatment of a resident that caused or may cause harm to the resident is required to contact the MLTC through the Action Line. The policy identified that the DOC or designate was responsible for following province specific reporting requirements. Inspector #693 reviewed Appendix 2, titled, "Jurisdictional Reporting Requirements", last updated in June 2019, the appendix identified that mandatory reporting under the LTCHA: Section 24 (1) of the LTCHA required a person to make an immediate report to the Director where there is reasonable suspicion that certain incidents occurred or may have occurred. The LTCHA provided that any person who had reasonable grounds to

suspect that any of the following had occurred, or may occur, must immediately report the suspicion and the information upon which it is based to the Director of the MLTC: improper or incompetent treatment or care of a Resident that resulted in harm or a risk of harm to the Resident.

During an interview with the DOC, they stated that if a resident was to be provided with continence assistance at a specified frequency and was only provided with assistance a specified amount of time during the shift, then that would be an example of improper care. Inspector #693 and the DOC reviewed the complaint and investigation notes for resident #002, from the complaint made. The DOC stated that it was the home's obligation to mandatory report the improper care that occurred from resident #002 not being provided their continence interventions in accordance with their continence care plan. The DOC confirmed that no CI report or Action Line notification was made for this incident of improper care and that a CI report should have been submitted. [s. 24. (1)]

Issued on this 9th day of December, 2019

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

Original report signed by the inspector.