Medical Health Officer Report to the Board:
Recommendation to Appoint an Administrator for Selkirk Seniors Village, 385 Waterfront Crescent, Victoria BC,

1. Introduction and Summary

The Island Health Community Care Facilities Licensing Program (Licensing Program) forwarded to me, on November 14, 2019, a Final Investigation Report regarding an investigation at Selkirk Seniors Village pursuant to Section 15(1)(b) of the *Community Care and Assisted Living Act* (the *Act*). The investigation covered the period between June 13, 2019 and August 30, 2019 during which time seven complaints were received and investigated. The Licensee of Selkirk Seniors Village was provided with a Summary of Apparent Findings Report on October 11, 2019. The Licensee responded to this report on October 28, 2019, and this response is included in the Final Investigation Report.

The duties and powers of the Medical Health Officer related to the *Community Care and Assisted Living Act* are listed in sections 13 through 16 of the *Act*. Some of these roles have been delegated to Licensing Officers working for the Island Health Licensing Program.

Section 13 of *the Act* allows the Medical Health Officer to suspend or cancel a licence, attach terms or conditions to a licence or vary the existing terms and conditions of a licence. Cancelling the licence would have a considerable negative impact on up to 217 residents living in the facility. It is my opinion, based on review of the Final Investigation Report, that attaching terms and conditions to the license for Selkirk Seniors Village will not effectively address the current risks to the health, safety and dignity of persons in care.

Section 23 of *the Act* empowers the Minister to appoint an Administrator for a specified period of time, if the Minister has reasonable grounds to believe that there is a risk to the health or safety of persons in care. This duty has been delegated to the Boards of the health authorities.

The appointment of an Administrator under section 23 is not considered an "action" for the purposes of reconsideration rights under section 17 of *the Act*. Consequently, the right of the Licensee to request the Medical Health Officer reconsider his or her decision, as in the usual process associated with attaching terms and conditions to or varying terms and conditions of a license or suspending or cancelling a license, does not apply to the appointment of an Administrator.

However, section 29 (2) of *the Act* does grant the Licensee a right to appeal the appointment of an Administrator within 30 days of receiving notification of that appointment to the Community Care and Assisted Living Board. The Board's decision to appoint an Administrator could be appealed pursuant to section 29 of *the Act*.

Section 23 of *the Act* states that the Administrator's fees will be deducted from the fees paid by the persons in care. All services for persons in care paid for by the government are to be made directly to the Administrator. If these funds are insufficient the Minister (the Board by delegation) will make up the difference. Essentially, the Licensee is responsible for payment.

Based upon the Licensing Program's investigation, the Program has concluded that the Licensee has consistently demonstrated that they are unwilling or unable to meet the minimum requirements set forth in legislation. The Licensing Program has recommended that an Administrator be appointed to Selkirk Seniors Village for a minimum of six months. Following careful review of the evidence provided to me in the Final Investigation Report, I agree with this recommendation.

It is therefore my advice that the Board of Vancouver Island Health Authority immediately appoints an Administrator as per Section 23 of the *Community Care and Assisted Living Act* for Selkirk Seniors Village for a period of time of not less than six months. The Administrator would be expected to work with the Licensee to ensure compliance with all requirements of the *Act* and to rebuild system stability and confidence in the operation of the facility.

2. Review of Evidence

Selkirk Seniors Village 3 LLP received an operating Licence effective February 16, 2017 and the Licence was varied on September 25, 2019 changing the distribution of funded and non-funded beds within the facility.

Prior to the initiation of the investigation covered in the Final Investigation Report, the risk rating for the facility was medium, based on a risk assessment completed on March 14, 2019. I have been informed by the Licensing Program that a risk assessment completed on November 28, 2019 has increased the risk rating to high.

Table 1 summarizes allegations at the facility under the current Licence. During the first year of operation there were 14 contraventions substantiated with four contraventions substantiated during the second year of operation. The rate of allegations increased beginning in June 2019 with seven allegations investigated up until August 30, 2019, the time period covered by the Final Investigation Report. Additional allegations have been received by the Licensing Program after October 2, 2019, as noted in the Final Investigation Report, but are still in process with no determination as yet of whether or not a contravention has occurred.

Table 1. *Table of Investigations.*

Date of Allegation	**Category**	**Status**	**Contraventions Yes/No**
March 7, 2017	Neglect	Completed	No
April 7, 2017	Emotional Abuse	Completed	Yes
April 11, 2017	Emotional Abuse	Completed	Yes
April 13, 2017	Neglect	Completed	No
April 18, 2017	Staffing	Completed	Yes
May 16, 2017	Aggression between persons in care	Completed	Yes
May 16, 2017	Staffing	Completed	Yes

May 21, 2017	Emotional Abuse	Completed	Yes
June 27, 2017	Neglect	Completed	Yes
June 29, 2017	Neglect and multiple concerns	Completed	Yes
June 30, 2017	Emotional and Physical Abuse	Completed	Yes
September 8, 2017	Emotional and Physical Abuse	Completed	Yes
September 21, 2017	Emotional Abuse	Completed	Yes
September 22, 2017	Food Service and Physical Plant	Completed	Yes
December 14, 2017	Health and Hygiene	Completed on Inspection Report	Yes
January 10, 2018	Emotional Abuse	Completed	No
January 26, 2018	Physical and Emotional Abuse	Completed	Yes
March 13, 2018	Medications	Completed	No
June 4, 2018	Health and Hygiene	Completed	No
July 27, 2018	Physical Abuse	Completed	Yes
July 31, 2018	Neglect and Staffing	Completed	Yes
August 13, 2018	Neglect	Completed	No
October 9, 2018	Physical Plant	Completed	Yes
January 9, 2019	Neglect	Completed	Yes
April 16, 2019	Physical Abuse	In process	Not determined
May 31, 2019	Unusual Behaviour	Completed	Yes
June 5, 2019	Neglect and Emotional Abuse	Completed	No
June 13, 2019	Medication, Record Keeping, Infection Control, Physical Plant, Nutrition and Dispute Resolution	In current Report	Yes
June 17, 2019	Staffing	In current Report	Yes
June 19, 2019	Medication and Dispute Resolution	In current Report	No
June 24, 2019	Neglect	In current Report	Yes
June 27, 2019	Neglect, Staffing and Dispute Resolution	In current Report	Yes
August 19, 2019	Medications and Staffing	In current Report	Yes
August 30, 2019	Neglect	In current Report	Yes
September 16, 2019	Neglect and Staffing	In process	Not determined
October 2, 2019	Neglect and Staffing	In process	Not determined
October 2, 2019	Neglect, Staffing and Nutrition	In process	Not determined
October 2, 2019	Unusual Behavior	In process	Not determined
October 10, 2019	Neglect, Notification of a Reportable Incident	In process	Not determined

October 11, 2019	Neglect	In process	Not determined
October 11, 2019	Neglect, Record Keeping and Dispute Resolution	In process	Not determined
October 11-16, 2019	Neglect, Staffing, Nutrition, Restraint Use, Physical Plant	In process	Not determined
October 17, 2019	Neglect, Bill of Rights, Physical Plant	In process	Not determined
October 18, 2019	Neglect	In process	Not determined
October 21, 2019	Neglect, Medication and Food Service	In process	Not determined
October 22, 2019	Neglect, Dispute Resolution and Record Keeping.	In process	Not determined
November 1, 2019	Staffing, Dispute Resolution	In process	Not determined

The substantiated contraventions, based on a balance of probabilities, in the Final Investigation Report covering the time period June 13, 2019 to August 30, 2019 include:

- *Community Care and Assisted Living Act*
  - Section 7(1)(b)(i) related to ensuring the health safety and dignity of persons in care
- *Residential Care Regulation*:
  - Section 22(1)(c) related to maintaining the facility in clean and safe condition
  - Section 42(1)(a)(b) related to sufficient staffing
  - Section 52(1)(a) related to neglect
  - Section 60(c) related to dispute resolution
  - Section 68(3)(b)(i) related to the administration of medication
  - Section 68(4) related to the documentation of medication
  - Section 69(3)(a) related to the storage of medication
  - Section 77(2)(c) related to notification of a reportable incident
  - Section 81(1) related to development of care plan
  - Section 81(3)(d) related to care planning for recreation and leisure
  - Section 81(4)(b)(i) related to updating care plans
  - Section 82 related to implementation of care plans
  - Section 85(1)(d) related to implementation of policies
  - Section 93 related to confidentiality

On review of the Final Investigation Report, it is apparent that a number of areas of recurring concern emerge as outlined below. Additional contraventions that are not covered under the headings below are outlined in the Final Investigation Report.

2.1 Staffing Coverage Not Sufficient

The level of staff coverage in the facility has not been adequate to meet the needs of persons in care. Multiple complaints have been made concerning staffing shortages throughout the facility and the impact this is having on resident care. A review by the Licensing Program substantiated that the number of Resident Care Aides (RCA), Licensed Practical Nurses (LPN) and Registered Nurses (RN) were all repeatedly below their expected complement during the period of time covered by the Final Investigation Report. The review also identified gaps in care that were related to deficient staffing coverage.

On September 18, 2019, the Licensing Program requested a Health and Safety Plan from the Licensee Contact related to staffing. The Licensee Contact provided a staffing plan on September 18, 2019 and an amended plan on September 20, 2019, both of which were not accepted by the Licensing Program because of significant gaps and insufficient detail. On September 26, 2019 the Licensing Program requested an amended Health and Safety Plan but has not, to date, received this from the Licensee.

The Licensee's written response, on October 28, 2019, to the Summary of Apparent Findings Report included a large volume of documentation of which much was not applicable to the investigations. On review it was apparent that the Licensee has not demonstrated an understanding of their role and responsibility in ensuring that sufficient strategies and actions have been implemented to guarantee appropriate staffing is in place at all times.

Beginning on October 11, 2019, Island Health has provided support to the facility through adding staff to one of the units. The support from Island Health for this unit includes 5 RCAs on days, 4 RCAs on evenings, 3 RCAs on nights, 1 LPN on all shifts, and 1 RN available at all times.

It is expected that the appointment of an Administrator would result in the development of staff recruitment strategies that ensure staff hiring in a manner such that the regulatory requirements for staff number, training and experience are met. They would also provide oversight, support and mentoring to identify and develop training and education for staff such that their competency aligns with their professional designation. The Administrator would build on existing practices to further develop and implement a sustainable and effective orientation for new staff.

2.2 Health, Safety and Dignity of Persons in Care

A key tenet of residential care in British Columbia is the right of persons in care to promotion and protection of their health, safety, and dignity, and Licensees have requirements to this effect under the *Community Care and Assisted Living Act* and the *Residential Care Regulation.* To ensure that these expectations are met, a Licensee is required to develop, implement, review and modify, as needed, care plans for each resident. A Licensee is also required to have written policies and procedures for the purposes of guiding staff in all matters relating to the care and supervision of persons in care; and ensure that policies are implemented by employees. The Licensee must also have written policies and procedures in respect of the continuing education of managers and employees.

Numerous concerns have been identified related to the health, safety and dignity of persons in care at Selkirk Seniors Village and are outlined in the Final Investigation Report. These include concerns related to documentation, wound care, bathing, supervision, medications, and storage of hazardous materials. The Licensing Program requested additional documentation from the facility manager on September 17, 2019 related to some of these concerns. As of the date of the Final Investigation Report, this documentation has not been received.

The Licensee's response to the Summary of Apparent Findings Report acknowledged that the facility had not followed a number of policies related to care and documentation, and that some care plans contained discrepancies or were missing information. The response was insufficient and lacked critical information in a number of areas. The Licensee has not demonstrated an understanding of their role and responsibility in ensuring that sufficient strategies have been implemented to ensure appropriate care planning practices and policies are implemented at all times.

2.3 Neglect

The Final Investigation Report has outlined concerns of neglect related to not ensuring care needs being met including bathing, wound care, comfort, and supervision. A further concern was failure to report to the Licensing Program reportable incidents related to neglect. The Licensee's response to the Summary of Apparent Findings Report acknowledged and indicated that staff have not ensured appropriate record keeping when discrepancies in records and care plans were identified. In addition, the site did not comply with the organizational and legislative requirements regarding notification of a reportable incident.

Other than the use of audits and education, the Licensee has not provided a sufficient plan of action that highlights the development, implementation, and monitoring required addressing deficiencies and ensuring the creation of sustainable protocols and systems are in place to ensure appropriate care is provided. The Licensee appears either unwilling or unable to provide an action plan that is responsive and reflects qualitative measures to ensure persons in care are not subjected to neglect.

2.4 Physical Plant

A number of concerns about the physical plant are outlined in the Final Investigation Report including broken window screens, lack of cleanliness, and the door being left open to a utility room containing cleaning supplies. The Licensee acknowledged, in their response to the Summary of Apparent Findings Report, that the site did not complete repairs in a timely manner as they arose and that the cleanliness of bathrooms and rooms were not up to the organizations standards. The Licensee failed to provide sufficient information, other than audits, to identify how education and support related to the cleanliness and maintenance of the facility would be ensured and maintained.

2.5 Meeting the requirements* of the *Continuing Care and Assisted Living Act.

The Licensee has the primary responsibility to operate a facility in compliance with the *Community Care and Assisted Living Act* (the *Act*) and Regulations. In order to assist the Licensee to meet their mandate the Licensing Program has invested significant time and support, including attending the Facility on a weekly basis since July 31, 2019.

I am concerned that where the Licensee has complied with the *Act* and Regulations to date this is partially due to the frequency of the Licensing Program's weekly onsite inspections and their specific requests for documentation. I do not have confidence that the Licensee would be able to continue to comply with the legislation without the Licensing Program's intervention.

While it appears some progress has been made through the hiring of a RN Educator, sufficient information has not been provided by the Licensee to determine the effectiveness of this role. The Licensee is required to fully satisfy the requirements of the *Act*, not just partially satisfy them.

The majority of licensed long term care facilities are able to meet or exceed the minimal requirements of the *Act* with little to no application of progressive enforcement. Yet the Licensee continues to move too slowly toward full compliance. This indicates to me that the Licensee is either unable or unwilling to meet their mandated responsibility of ensuring health, safety and dignity of persons in care.

An appointed Administrator would act as a bridge between the Licensee and the Licensing Program to empower the Licensee with the tools and systems for sustained and independent provision of competent and compliant care.

3. Options Analysis, Rationale and Recommendation.

Based upon the number and nature of contraventions outlined in the Final Investigation Summary, it is my opinion that action is required to protect the health, safety, and dignity of persons in care at Selkirk Seniors Village.

The Licensing Program considered the option of recommending that conditions be placed on the Licence of the facility. Given the Licensee's inability to fully comply with legislation, and inability to provide sufficient details with corrective action measures, the Licensing Program believes that placing conditions on the Licence would be ineffective. I concur with this analysis and do not recommend the placement of conditions on the Licence to address the current situation.

Further, given the considerable negative impact that cancelling the Licence would have on up to 217 residents living in the facility, I do not recommend this option.

Following careful review of the evidence provided to me in the Final Investigation Report, I agree with the recommendation from the Licensing Program that an Administrator be appointed to Selkirk Seniors Village for a minimum of six months. The appointment of an Administrator will result in:

- The development of staff recruitment strategies that ensure staff hiring in a manner such that the regulatory requirements for staff number, training and experience are met (as noted in section 2.1).

- Oversight, support and mentoring in the development and improvement on resident focused training, education and care, facility wide to strengthen the competency of staff according to their professional designation.

- Oversight, mentoring and support to ensure that all audits and any other additional audit tools required are completed appropriately and assessed to ensure that the care plans for persons in care are reflective of their current care needs and that safe and appropriate care is provided.

- Oversight, mentoring and support in the completion of effective and achievable health and safety plans, and corrective action plans acceptable to Licensing. The Administrator would be key in providing guidance, oversight in ensuring that follow up is completed related to the plans stated above, and that a designated individual is responsible for the follow up and reports accordingly.

- Oversight, mentoring and guidance to build on existing practices and further develop and implement a sustainable and successful orientation and onboarding process for new staff.

- A collaborative approach to support the Licensee in ensuring that compliance with the legislation is achieved.

I therefore recommend to the Board of the Vancouver Island Health Authority that an Administrator be appointed through their delegated authority under section 23 of the *Community Care and Assisted Living Act*. Further, I recommend that this appointment continue for a time period of not less than six months.

4. Regarding the Administrator

Recommended Administrator: Susan Abermann. Contact information and qualifications are enclosed as Appendix A.

5. Terms of Reference for Administrator

A draft terms of reference for the prospective Administrator is enclosed as Appendix B. It is recommended that the letter appointing the Administrator include the following terms:

- That the Administrator is a representative of Island Health s.13
s.13
- The Administrator's contact person at Island Health will be Lisa Grant, Residential Licensing Officer, 201-771 Vernon Avenue, Victoria BC.
- That the Administrator is to take his or her instructions from the Board; and

- A clause in which the Board may terminate the appointment of the Administrator earlier than the termination date of the appointment in its sole discretion.

6. Notice to Licensee and Persons in Care

Once the Board has made a decision to appoint an Administrator, it must serve notice of that appointment to the Licensee.

Enclosed as Appendix C is a draft letter giving the Licensee notice of the appointment of an Administrator.

It is recommended that a written notice of the appointment be sent to the Minister of Health although this is not a statutory requirement.

The Board should also plan to notify the individuals in care and their families of the appointment of an Administrator.

Sincerely,

Murray Fyfe, MD, MSc, FRCPC
Medical Health Officer

Pages 10 through 15 redacted for the following reasons:
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s.13
s.22