



**Ministry of Health and
Long-Term Care**

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

**Ministère de la Santé et des
Soins de longue durée**

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

**Health System Accountability and
Performance Division
Performance Improvement and
Compliance Branch**

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 30, 2015	2015_270531_0017	O-002289-15	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H
5L8

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

Warkworth Place
97 Mill Street P.O. Box 68 Warkworth ON K0K 3K0

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

SUSAN DONNAN (531), CAROLINE TOMPKINS (166), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): July 20, 21, 22, 23, 24, 27 and 28, 2015.

The following inspection logs were included in this inspection:

Log# O-001937-15, O-002494-15, O-001993-15, O-002307-15, O-002393-15 and O-001621-15.

During the course of the inspection, the inspector(s) spoke with Residents, resident family members, Personal Support Workers, Registered Practical Nurses, Register Nurses, the Activation staff, Director of Care and the Administrator. During the course of the inspection, the inspectors observed resident care and services, reviewed resident health care records including physician orders, consult reports and policy and procedures.

The following Inspection Protocols were used during this inspection:

**Contenance Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care**

During the course of this inspection, Non-Compliances were issued.

**1 WN(s)
0 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

Legendé

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 O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. Related to Log # O-001621-15

The licensee has failed to ensure that Resident #50's Substitute Decision Maker was notified of the results of the alleged verbal abuse investigation immediately upon the completion.

Critical Incident Report #2803-000003-15 was received identifying that on a specified date, the licensee had been made aware of allegations that RPN #120 spoke to Resident #50 in an inappropriate and threatening tone of voice.

The licensee initiated an internal investigation and notified Resident #50's Substitute Decision Maker of the incident upon becoming aware of the allegation of abuse.

Review of Resident #50's records, the critical incident documentation and the licensee's investigation indicated that Resident # 50's Substitute Decision Maker was not notified of the results of the investigation into the allegation of verbal abuse directed toward this resident.

The Administrator was interviewed and confirmed that there is no documentation that the Substitute Decision Maker had been notified of the results of the investigation. [s. 97. (2)]



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Issued on this 30th day of July, 2015

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

Original report signed by the inspector.