Ontario

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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 27, 2016	2016_195166_0026	011339-15, 013886-15, 011522-16, 011810-16, 013147-16, 013896-16, 017025-16, 019116-16, 019744-16, 020895-16, 021545-16, 023956-16, 024550-16, 025421-16, 028411-16	Critical Incident System

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

Hope Street Terrace
20 HOPE STREET SOUTH PORT HOPE ON L1A 2M8

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

CAROLINE TOMPKINS (166)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 12, 13, 14, 19, 20, 21, 22, 2016

Critical Incident Reports (CIR) logs, 011339-15, 013886-15, 013896-16, 019116-16, 020895-16, 024550-16, 025421-16, related to allegations of resident to resident physical abuse, logs 011522-16, 019474-16 related to allegations of staff to resident verbal, emotional and physical abuse, logs 011810-16, 013147-16 related to missing resident, log 017025-16 related to a breakdown in equipment, log 021545-16 related to resident care, log 023956-16 related to an unexpected death and log 028411-16, related to a fall, were inspected concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family, Personal Support Workers(PSW), Registered Nurses(RN), Registered Practical Nurses(RPN), Behaviourial Support Ontario(BSO), Administrator and Director of Care(DOC)
During the course of this inspection, the inspector observed staff to resident and resident to resident interactions, reviewed the licensee's investigations documentation, the licensee's policy #OPER-02-02-04 related to zero tolerance of abuse and reviewed clinical documentation.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home

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

- **4 WN(s)**
- **4 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. related to log 011522-16
The licensee has failed to ensure that the care set out in the plan of care was provided to resident #007 as specified in the plan.
A Critical Incident Report (CIR) was received indicating that staff#101 had reported an allegation of staff to resident verbal and emotional abuse.
Review of the licensee's investigation indicated that on a specified date, RPN#102 was extremely abrupt with resident #007, when attempting to provide a treatment, causing the resident to become agitated and upset.
Staff#101 attempted to calm resident #007, RPN#102 continued to attempt to provide the treatment, even as resident #007's agitation escalated.
Written statements from 3 staff members who witnessed the incident indicated that when resident #007 became agitated and upset with RPN#102 and as staff#101was removing the resident from the area, RPN#102 was overheard making a statement to resident #007 indicating that if resident #007 did not stop reacting, the resident would receive an injection.
Review of resident #007's plan of care related to behaviours indicated resident #007 can display physical and verbal behaviours and can become easily agitated.
Interventions included:
--provide 1:1 interventions with BSO to assist in de-escalation- calming activities.
-provide concise explanation of care and treatment to resident prior to initiating to promote understanding and acceptance
-provide for flexibility in activities of daily living(ADL) routine to accommodate resident's mood leaving and returning later.

Review of licensee's investigation record, interview with the Administrator and staff#101 indicated that RPN #102 did not follow resident #007's plan of care, did not provide flexibility with the resident's ADL routine, did not provide concise explanation of care and treatment and as resident #007's behaviour escalated, RPN#102 did not accommodate

resident #007 by leaving and returning later to provide treatment. [s. 6. (7)]

2. related to log 028411-16
The licensee has failed to ensure that the care set out in the plan of care for resident #016 was provided to the resident as specified in the plan.
A Critical Incident Report was received, reporting that a staff member was passing resident #016's room and heard a call for help. Resident #016 was found lying beside the bed.
Clinical documentation indicated resident#016 was assessed, no apparent injuries were noted.
The next day following the incident, staff observed a change in the resident's physical status. Resident#016 was transferred to the hospital for further assessment.

Review of clinical documentation, including resident #016's plan of care, interview with the Administrator, RPN #117 and PSW #116 indicated that a safety device is applied on the bed and when resident #016 is put into bed, staff are to check that the device is positioned correctly, is plugged in and is working.

Interview with the Administrator, RPN #117 and review of the licensee's investigation indicated that on the day of the incident, the safety device was unplugged and therefore did not alert staff when resident #016 fell. [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 the care set out in the plan of care for all residents, who have been assessed related to responsive behaviours is provided to those residents, as specified in the plan.
The licensee is also requested to ensure that the safety device for resident #016 and for all other residents who use the same type of safety device is applied correctly,is plugged in and is working, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. related to log 011522-16
The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with.
A Critical Incident Report(CIR) was received reporting an alleged incidence of staff to resident abuse.
The CIR documentation indicated that staff #101 reported a witnessed incident of staff to resident verbal and emotional abuse .
Review of the licensee's policy, Resident Abuse- Staff to Resident reference #OPER-02-02 states:
related to responding and reporting:
All staff- Immediate report(verbally)any suspected or witnessed abuse to the Administrator, Director of Care, or their designate (e.g. supervisor, department head).
The alleged witnessed staff to resident verbal/emotional abuse was reported two days after it was witnessed, contra to the licensee's policy which requires all staff to immediately report any suspected or witnessed abuse of a resident. [s. 20. (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 to ensure that the licensee's policy to promote zero tolerance of abuse and neglect of residents, specifically, the immediately reporting of any witnessed or suspected abuse is complied with, 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. Related to Log 025421-16
The licensee has failed to ensure that abuse of a resident by anyone that resulted in harm or a risk of harm to a resident was immediately reported to the Director:
An incident of a physical altercation which occurred on a specified date, by resident #003 directed towards resident #006 which resulted in an injury(skin tear) to resident #006 was not reported to the Director until three days post incident. [s. 24. (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 to ensure abuse of a resident by anyone that resulted in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. Related to log 013886-15, 013896-16, 025421-16

The licensee has failed to ensure that procedures and interventions are developed and implemented: to assist residents who are at risk of harm or who are harmed as a result of resident #003's responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Review of clinical documentation and interviews with the Administrator, Behavourial Support Ontario staff member, Personal Support Workers and Registered staff indicated resident #003 displays responsive behaviours, which includes both verbal and physical aggression directed towards other residents and staff. Four of the incidents of physical aggression by resident #003 resulted in injuries to four co -residents
Some triggers for these responsive behaviours have been identified and responsive behaviour plans of care which includes interventions to assist in mitigating aggressive behaviours have been developed and implemented, however resident #003 continues to be involved in incidents of resident to resident physical aggression that often results in injuries to other residents

Therefore the licensee has failed to minimize the risk of altercations and potentially harmful interactions between and among residents. [s. 55. (a)]

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 procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of resident #003's responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

Issued on this 27th day of September, 2016

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

Original report signed by the inspector.