Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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
Sep 26, 2019	2019_670571_0016	010734-19, 013498-19, 016432-19	Critical Incident System

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

Hope Street Terrace
20 Hope Street South PORT HOPE ON L1A 2M8

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

PATRICIA MATA (571)

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 11, 12, 13 and 16, 2019.

The following logs were inspected:
Log #013498-19 and 010734-19 related to unsafe transfers.
Log #016432-19 related to missing narcotics.

During the course of the inspection, the inspector(s) spoke with acting Administrator, acting Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary Manager, Physiotherapist, Nursing Clerk and Activity Aides.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for resident #001 that set out clear directions to staff regarding a specified area of care.

Related to log # 010734-19:

A Critical Incident Report was submitted to the Director for an allegation of neglect occurring on an identified date.

A review of the progress notes by Inspector #571 for an identified date indicated that the Activation Aide (AA) #108 observed resident #001 receiving a specified area of care in a specific manner.

A review of the plan of care in place on the identified date related to the specified area of care included specific instruction for staff regarding how to provide the specified area of care.

During an interview on an identified date with Inspector #571, resident #001 indicated the way in which they preferred a specified area of care be provided.

During an interview with Inspector #571, PSW #105 indicated that on the identified date, resident #001 had asked them to provide the specified area of care in the manner that the resident preferred. PSW #105 told the resident that they would provide the care as specified in the plan of care rather than as described by the resident. The resident explained to PSW #105 why they preferred care in the manner that the resident had requested. PSW #105 proceeded to provide the care as the resident wished.

During an interview with Inspector #571, PSW #110 indicated that they had provided the specified area of care to resident #001. PSW #110 indicated that they were uncertain how the care should have been provided. When asked by Inspector #571 how a new staff or agency staff would know how to provide the specified area of care to the resident as the resident, PSW #110 indicated that the resident would talk them through the process.

On an identified date, the acting Director of Care provided Inspector #571 "General Staff Meeting" minutes from an identified month. The acting Director of Care highlighted the section related to the specified care area mentioned for resident #001.

The licensee failed to ensure that resident's plan of care set out clear direction to staff. It did not direct staff how the resident preferred to be provided the specified care area and the correct method of providing the care. [s. 6. (1) (c)]

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 by ensuring that the written plans of care set out clear direction for staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that the staff use safe transferring techniques when assisting resident #001.

Related to resident #001 for log # 010734-19 and 013498-19:

Two Critical Incident Reports were submitted to the Director for an allegation of neglect and an allegation of improper treatment that results in risk of harm to a resident occurring on two separate dates. In both incidents, staff did not use safe transferring techniques when providing care to resident #001.

Two of the licensee's policies, LP-01-01-01 last updated on August 2017 and policy LP-01-01-02 last update August 2017, provided direction to staff regarding safe transferring techniques.

During an interview with Inspector #571, resident #001 indicated that safe transferring techniques were not used during the provision of care on the two identified dates and on other unidentified dates.

During separate interviews with Inspector #571, PSW #105, #107, #104 and #110 described how they transferred resident #001 during care. Each description was not compliant with the licensee's policies for safe transferring techniques.

During an interview with Inspector #571, RN #102 indicated that on an identified date, they were informed of an incident involving resident #001. The RN was concerned that staff had not used safe transferring techniques when assisting resident #001.

During an interview with Inspector #571, RPN #116 indicated that on an identified date, they discovered that staff had not used safe transferring techniques when caring for resident #001. RPN #116 indicated that it is their expectation that staff use safe transferring techniques as per the licensee's policies.

A review of the licensee's investigation interview form completed by the former Director of Care after the first incident, indicated that PSW #105 was reminded to use safe transferring techniques.

On an identified date, the acting Director of Care provided Inspector #571 "General Staff Meeting" minutes from an identified month. The acting Director of Care highlighted the section that included safe transferring techniques. At the meeting, staff were reminded of the policy on safe transferring techniques.

The licensee failed to ensure that staff use safe transferring techniques when assisting resident #001. [s. 36.]

2. Related to resident #002:

Non-Compliance was identified while inspecting log #010734-19 and 013498-19. The scope was expanded to include resident #002. On an identified date, Inspector #571 observed PSW #117 not using safe transferring techniques while providing care to resident #002. PSW #117 acknowledged that they had not used safe transferring techniques because the resident had been in a hurry.

On an identified date, the acting Director of Care indicated to Inspector #571, that PSW

#117 had self reported to the charge RN that she had used unsafe transferring techniques while providing care to resident #002.

The licensee failed to ensure that staff use safe transferring techniques while providing care to resident #002. [s. 36.]

3. Related to resident #004:

Non-Compliance was identified while inspecting log #010734-19 and 013498-19. The scope was expanded to include resident #004.

A review of the plan of care for resident #004 indicated the resident required specified care and that staff were to use safe transferring techniques during the provision of the care.

During an interview with Inspector #571, RN #114 indicated that on some occasions staff have not used safe transferring techniques while providing the specified care.

The licensee failed to ensure that staff used safe transferring techniques when providing care to resident #004. [s. 36.]

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 by ensuring that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 17th day of October, 2019

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

Original report signed by the inspector.