Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
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Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Public Report

Report Issue Date: December 13, 2024

Inspection Number: 2024-1147-0003

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)

Long Term Care Home and City: Hope Street Terrace, Port Hope

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 2, 3, 5, 6, 10-13, 2024
The inspection occurred offsite on the following date(s): December 4, 9, 2024
The following intake(s) were inspected:

- Three intakes related to a missing resident
- Intake related to first follow-up #001 from inspection #2024_1147_0002 related to O. Reg. 246/22 s. 146 (b) with a CDD October 7, 2024
- Intake related to first follow-up #002 from inspection #2024_1147_0002 related to O. Reg. 246/22 s. 147 (2) (b) CDD October 7, 2024
- Three intakes related to anonymous complaints.
- Intake related to neglect of resident

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1147-0002 related to O. Reg. 246/22, s. 146 (b)
Order #002 from Inspection #2024-1147-0002 related to O. Reg. 246/22, s. 147 (2) (b)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Safe and Secure Home
Staffing, Training and Care Standards
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
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.

The licensee has failed to ensure the provision of care for turning, repositioning, and checking for continence set out in the plan of care for a resident was documented. A resident was to be turned and repositioned every two hours through the night and when in bed, as well as checked for continence. Documentation was missing on multiple dates.

Sources: resident documentation survey records and care plan, interview with staff.

WRITTEN NOTIFICATION: Menu Planning

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (1) (c)
Menu planning
s. 77 (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes a choice of beverages at all meals and snacks

The licensee has failed to ensure that the home's menu cycle, includes a choice of beverages at all meals and snacks.

On a specific date, on three dining areas during the lunch meal service, it was observed that only water and milk were offered. On a different date, one dining area offered water, milk, and coffee. Two residents confirmed they were not offered any juice or choice of beverages, and a resident was only offered coffee. The dietician confirmed that all residents should be offered a variety of beverages in various textures.

Sources: Observations, record review of posted menu, interviews with residents, interviews with staff.

WRITTEN NOTIFICATION: Menu Planning

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (8)

Menu planning
s. 77 (8) The licensee shall ensure that food and beverages, including water, that are appropriate for the residents' diets are accessible to staff and available to residents on a 24-hour basis. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure that food and beverages, including water, that are appropriate for the residents' diets are accessible to staff and available to residents on a 24-hour basis on the second and third floors.

Servery fridges on the second and third floors inconsistently contained milk, crème. No juice, water, or food products of different consistencies were observed. A PSW indicated the unavailability of varied beverages and food textures during evening and night shifts. The dietician confirmed that food and beverages, including water of different textures are to be always available to staff and residents.

Sources: Observations, interviews with staff.

WRITTEN NOTIFICATION: Dealing with complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 2.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that

complies with paragraph 3 shall be provided as soon as possible in the circumstances.

The liscensee has failed to ensure that when a complaint regarding a resident was received, that when it could not be investigated and resolved within 10 business days, a date by which the complainant could reasonably expect a resolution, and a follow-up response was not provided.

The investigation into the complaint was not completed within the required ten business days, and the substitute decision maker (SDM) for the resident, was not informed of the results of the investigation until 32 days later.

Sources: Review of the home's complaints binder, and interviews with staff.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. i.
Dealing with complaints
s. 108 (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. The response provided to a person who made a complaint shall include,
i. the Ministry's toll-free telephone number for making complaints about homes and its hours of service and contact information for the patient ombudsman under the Excellent Care for All Act, 2010,

The licensee has failed to ensure that when a written complaint was made to the licensee concerning the care of a resident, a response was provided to the complainant that include, the Ministry's toll-free telephone number for making complaints and its hours of service.

Sources: Acknowledgement and final response letters, interview with staff.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 4. ii.
Reports re critical incidents

s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 4. Analysis and follow-up action, including, ii. the long-term actions planned to correct the situation and prevent recurrence.

The licensee failed to implement, the long-term actions identified in the Critical Incident Report (CIR), to prevent recurrence of a resident eloping from the home. The Director of Care confirmed when the Director was informed of long-term actions to prevent recurrence of resident eloping, the staff education and environmental assessments were not implemented.

Sources: CIR, interview with staff.