



**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 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**

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
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Public Copy/Copie du public

Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 7, 2016	2016_461552_0021	013961-16, 019883-16	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

Port Perry Place
15941 Simcoe Street Port Perry ON L9L 1N5

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

MARIA FRANCIS-ALLEN (552)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): July 27, 28, 29, August 2, 3, & 4, 2016

Critical Incident log #019883-16 and #013961-16 related to falls

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Nurses RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents

Also observed staff to resident interaction during provision of care, review of clinical health records and policies related to Falls and Abuse and Neglect

**The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation**

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

2 WN(s)

0 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**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. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan

Regarding log #013961-16

A Critical Incident Report (CIR) was submitted on an identified date indicating that ten days earlier, resident #008 fell while left unattended by PSW #107.

During the investigation conducted by the licensee, PSW #107 admitted resident #008 was left unattended in the shower room. PSW #107 further explained during the investigation that PSW#108 was also in the shower room providing care for another resident but that she had not told PSW #108 she was leaving the resident unattended. PSW #108 confirmed to the management during their investigation that PSW #107 had not communicated with her about the resident being left unattended and that she was focused on providing care to another resident. PSW #108 commented however, that she knew the resident had been left unattended.

Review of the clinical health records indicated resident #008 was admitted to the home with several medical diagnosis.

Review of documentation in the clinical health records, including the kardex and care plan directed staff to not leave resident #008 unattended while the resident was being toileted.

During an Interview with PSW #107 she explained this was the first time she was providing care for the resident and that she usually worked on a different home area. She explained she did not review the resident's plan of care and had left the resident on the toilet unattended .

During an interview with PSW #114 , she explained resident #008 could not be left unattended while being toileted.

During an interview with the DOC (who is in charge of falls prevention) she explained the kardex provides all the information for staff surrounding the resident's needs and routine. She agreed the care provided to resident #008 was not as specified in the plan of care [s. 6. (7)]



Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 :



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1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director?

1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.

Regarding log #013961-16

A CIR was submitted by the home indicating that ten days earlier, resident #008 fell while left unattended by PSW #107.

During the investigation, PSW #107 admitted the resident was left in the shower room unattended. Resident #008 sustained injuries and was subsequently sent to the hospital.

The Director was not notified of the incident which resulted in harm to the resident until 10 days after the resident's fall and transfer to hospital. [s. 24. (1)]

Issued on this 7th day of September, 2016

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

Original report signed by the inspector.



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Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
Homes Act, 2007, S.O. 2007, c.8*

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée, L.O. 2007, chap. 8*

**Long-Term Care Homes Division
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**Division des foyers de soins de longue durée
Inspection de soins de longue durée**

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : MARIA FRANCIS-ALLEN (552)

Inspection No. /

No de l'inspection : 2016_461552_0021

Log No. /

Registre no: 013961-16, 019883-16

Type of Inspection /

Genre

d'inspection:

Critical Incident System

Report Date(s) /

Date(s) du Rapport : Sep 7, 2016

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

LTC Home /

Foyer de SLD :

Port Perry Place
15941 Simcoe Street, Port Perry, ON, L9L-1N5

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur :

Marva Griffiths

To CVH (No.6) GP Inc. as general partner of CVH (No.6) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:



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

Order(s) of the Inspector

Pursuant to section 153 and/or
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**Ministère de la Santé et
des Soins de longue durée**

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou
de l'article 154 de la *Loi de 2007 sur les foyers
de soins de longue durée*, L.O. 2007, chap. 8



Order # /
Ordre no : 001 **Order Type /**
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall hereby ensure:

- all staff are aware of the care specifics for residents they are assigned to provide care to
- when residents are being toileted, staff provide needed assistance and monitoring of these residents
- the registered staff monitors the front line staff to ensure the care being provided is as outlined in the resident's plan of care

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #008 as specified in the plan

A Critical Incident Report was submitted on an identified date indicating that ten days earlier, resident #008 fell while left unattended by PSW #107 in the shower room.

During the investigation conducted by the licensee, PSW #107 admitted resident #008 was left unattended in the shower room. PSW #107 further explained during the investigation that PSW #108 was also in the shower room providing care for another resident but she had not told PSW #108 she was leaving resident #008 unattended. PSW #108 confirmed to the management during their investigation that PSW #107 had not communicated with her about resident #008 being left unattended and she was focused on providing care to another resident. PSW #108 commented however that she knew the resident had been left unattended on the toilet seat.

Review of the clinical health records indicated resident #008 was admitted to the



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

Order(s) of the Inspector

Pursuant to section 153 and/or
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Homes Act, 2007, S.O. 2007, c.8*

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

Ordre(s) de l'inspecteur

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de soins de longue durée, L.O. 2007, chap. 8*

home with several medical diagnosis. The resident's care plan and kardex both indicated staff should not leave the resident unattended while the resident was being toileted.

Interview with PSW #107 she explained this was her first time providing care for resident #008 and that she usually worked on a different home area. She explained resident #008 required 2 staff members to transfer on the toilet and had been told by the regular staff members that resident #008 normally sits on the toilet for 15 minutes. PSW #107 stated she did not review the resident's plan of care and had left the resident unattended.

During an interview with PSW #114, she explained resident #008 could not be left unattended when being toileted.

During an interview with the Director of Care (who is in charge of falls prevention) she explained the kardex would provide all the information for staff surrounding the resident's needs and routine. She agreed the care provided to the resident was not as specified in the plan.

A compliance order is being issued because although the scope was isolated, the severity of this incident was high in that failure to provide care to resident #008 as specified in the plan of care resulted in actual harm. (552)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016



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Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur

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de soins de longue durée*, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

- (a) the portions of the order in respect of which the review is requested;
- (b) any submissions that the Licensee wishes the Director to consider; and
- (c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603



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When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.



**Ministry of Health and
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Ordre(s) de l'inspecteur
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de soins de longue durée, L.O. 2007, chap. 8*

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

- a) les parties de l'ordre qui font l'objet de la demande de réexamen;
- b) les observations que le titulaire de permis souhaite que le directeur examine;
- c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



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Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 7th day of September, 2016

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Maria Francis-Allen

Service Area Office /

Bureau régional de services : Ottawa Service Area Office