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 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
May 10, 2019	2019_664602_0024	005090-18, 006717-19, 008342-19	Critical Incident System

Licensee/Titulaire de permis

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

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

Regency Long Term Care Home
66 Dorset Street East PORT HOPE ON L1A 1E3

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

WENDY BROWN (602)

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): May 6, 7 & 8, 2019

Log# 005090-18/CIS 2511-000002-18 - regarding an incident causing injury for which a resident is taken to hospital.
Log# 008342-19/CIS 2511-000004-19 - regarding alleged resident to resident sexual abuse.
Log# 006717-19/CIS 2511-000003-19 - regarding alleged resident to resident physical abuse.

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

In addition, observations of resident care service delivery, and reviews of the electronic health care record, meeting minutes, PointClickCare communications and relevant policies/procedures were completed.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 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	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. (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 comply with LTCHA 2007. s. 6 (7) in that the care set out in the residents plan of care was not provided as specified in the plan.

The following finding is related to Log # 006717-19:

On a specified date at a specified time, resident #003 was self-propelling in their wheelchair down the hallway when they were observed kicking a co-resident. The residents were separated, assessed and offered support/care.

A similar incident occurred a specified period of time previously when resident #003 was observed hitting a co-resident in the hallway. Another incident followed noting resident #003 was kicking another co-resident while in the hallway. Resident #003 had been self-propelling back to their room.

The plan of care noted resident #003 was to be escorted to their room after meals and activities.

Inspection interviews with Director of Care (DOC) #101 and PSWs: #109, #110, #102, Registered Nurse (RN) #111 and the RAI Coordinator (RAI C) #112 confirmed staff were aware of the need to escort resident #003 to their room after meals and activities.

Resident #003 was not provided assistance back to their room on a specified date at a specified time as per their care plan. [s. 6. (7)]

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 :

1. The licensee has failed to ensure that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm was immediately reported to the Director

The following finding is related to Log # 006717-19:

As outlined in WN #1, a witnessed incident of resident to resident physical abuse occurred on a specified date at a specified time.

The DOC (#101) indicated that they were notified of the witnessed incident of abuse at a specified time, however, the DOC was unable to alert the Director until the following day due to time constraints and CI System challenges.

A person who had reasonable grounds to suspect there had been an abuse of a resident failed to immediately report the suspicion and the information upon which it was based to the Director (Ministry of Health and Long-Term Care). [s. 24. (1)]

Issued on this 10th day of May, 2019

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

Original report signed by the inspector.