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
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: July 25, 2024
Inspection Number: 2024-1080-0001
Inspection Type: 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: Regency Long Term Care Home, Port Hope

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 16-19, 22, and 23, 2024.

The following intake(s) were inspected:

- Follow-up #1 – CO #001, O. Reg. 246/22, s. 286 (7) (b), Trust accounts in #2023-1080-0004, with a CCD for May 30, 2024.

- Follow-up #1 – CO #002, O. Reg. 246/22, s. 41 (1) (a), Personal items and personal aids in #2023-1080-0004, with a CDD for May 30, 2024.

- Follow-up #1 – CO #003, O. Reg. 246/22, s. 58 (4), Responsive behaviours in #2023-1080-0004, with a CDD for May 30, 2024.

- Follow-up #1 – CO #004, O. Reg. 246/22, s. 59 (b), Altercations and other interactions between residents in #2023-1080-0004, with a CDD for May 30, 2024.

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- Follow-up #1 – CO #005, FLTCA, 2021, s. 24 (1) Duty to protect in #2023-1080-0004, with a CDD for May 30, 2024.

- Follow-up #1 – CO #006, O. Reg. 246/22, s. 12 (1) 3, Doors in a home in #2023-1080-0004, with a CDD for May 30, 2024.

- Follow-up #1 – CO #008, FLTCA, 2021, s. 25 (1), Policy to promote zero tolerance in #2023-1080-0004, with a CDD for May 30, 2024.

- Follow-up #1 – CO #009, O. Reg. 246/22, s. 78 (3) (b), Food production in #2023-1080-0004, with a CDD for May 30, 2024.

- Follow-up #1 – CO #010, O. Reg. 246/22, s. 79 (1) 5, Dining and snack service in #2023-1080-0004, with a CDD for May 30, 2024.

- Follow-up #1 – CO #007, O. Reg. 246/22, s. 102 (2) (b), Infection prevention and control program in #2023-1080-0004, with a CDD for May 30, 2024.

- An intake regarding an unexpected death of a resident.

- An intake regarding a fall of a resident that resulted in an injury.

- Two intakes regarding allegations of staff to resident abuse.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2023-1080-0004 related to O. Reg. 246/22, s. 286 (7) (b) inspected by the Inspector.

Order #002 from Inspection #2023-1080-0004 related to O. Reg. 246/22, s. 41 (1) (a) inspected by the Inspector.

Order #003 from Inspection #2023-1080-0004 related to O. Reg. 246/22, s. 58 (4) inspected by the Inspector.

Order #004 from Inspection #2023-1080-0004 related to O. Reg. 246/22, s. 59 (b) inspected by the Inspector.

Order #005 from Inspection #2023-1080-0004 related to FLTCA, 2021, s. 24 (1) inspected by the Inspector.

Order #006 from Inspection #2023-1080-0004 related to O. Reg. 246/22, s. 12 (1) 3. inspected by the Inspector.

Order #007 from Inspection #2023-1080-0004 related to O. Reg. 246/22, s. 102 (2) (b) inspected by the Inspector.

Order #008 from Inspection #2023-1080-0004 related to FLTCA, 2021, s. 25 (1) inspected by the Inspector.

Order #009 from Inspection #2023-1080-0004 related to O. Reg. 246/22, s. 78 (3) (b) inspected by the Inspector.

Order #010 from Inspection #2023-1080-0004 related to O. Reg. 246/22, s. 79 (1) 5. inspected by the Inspector.

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

- Resident Care and Support Services
- Food, Nutrition and Hydration
- Infection Prevention and Control
- Safe and Secure Home
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Falls Prevention and Management
- Resident Charges and Trust Accounts

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 2.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to have their lifestyle and choices respected.

The licensee has failed to ensure that a resident's rights were fully respected and promoted to have their choices respected.

Rationale and Summary

A CI was submitted to the Director with allegations that a PSW was emotionally abusive towards a resident when they took away the resident's snack. The internal investigation determined the resident yelled at the PSW to return their snack. The resident could not recall the incident the following morning. The allegations were substantiated, and the Resident's Bill of Rights was violated when the PSW with-held the resident's snack. The Director of Care (DOC) confirmed the allegations were substantiated.

The resident was upset when their snack was taken away and they were denied their choice of food.

Sources: A CI, internal investigation notes, progress notes, care plan, and interview with the DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The licensee has failed to ensure that a report was immediately submitted to the Director after a Registered Nurse (RN) witnessed staff to resident verbal, emotional, and physical abuse.

Rationale and Summary

A CI was submitted to the Director involving three residents with allegations of staff to resident abuse.

The DOC indicated they submitted the CI and began the internal investigation immediately upon being informed of the allegations. The RN submitted a written statement to the DOC, upon request by the DOC regarding the allegations of staff to residents' abuse. The internal investigation determined the RN had concerns regarding the PSWs approach with resident care over an extended period, and they did not immediately report their observations. The DOC reported the allegations were not substantiated and that the RN should have immediately reported the allegations of abuse to the Director.

By not ensuring the Director was immediately informed of allegations of staff to resident abuse placed the residents at risk due to a lack of transparency and communication with the Director.

Sources: A CI, internal investigations, and interview with the DOC.

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary

A CI was submitted to the Director related to the resident's unwitnessed fall which resulted in an injury.

A resident was found on the floor with a specified injury and reported pain. The RPN and RN manually transferred the resident from the floor to the bed. The RPN acknowledged that they did not follow safe transferring techniques putting the resident at further risk.

Failing to ensure that staff used safe transfer and positioning techniques resulted in risk of injury to the resident.

Sources: A CI, internal investigation notes, and interview with a Registered Practical Nurse (RPN).

COMPLIANCE ORDER CO #001 Plan of care

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee shall:

1.Educate PSW, and RN on the different types of feeding assistance, the importance of following residents' care plan when eating, and the policies and procedures to prevent residents from choking. Have the staff sign off that they have received the education.

2.Keep a documented record of the education provided, along with the staff sign-in sheets, dates of the education, who provided the education, and the content of the education provided. Make immediately available to Inspectors upon request.

3.Management are to conduct audits three times weekly of all residents who are at high risk for choking and require assistance when eating. The audits are to be conducted during evening meals and evening nourishments for a period of two weeks to ensure a staff member is assisting until all residents have completed their food and fluid intake. Keep a documented record of the audits completed and provide the audits to the Inspector immediately upon request.

4. The Director of Care will develop and implement a process to ensure that all residents are supervised by staff during dining and snack services. A record will be kept of this plan and how it is communicated to all staff who assist with resident's meals and snacks. This record will be made available to the inspector immediately upon request.

Grounds
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.

Rationale and Summary

A CI was submitted to the Director related to the resident's choking incident and unexpected death.

The CI indicated that the resident was found in their room choking . The resident's roommate alerted the staff by yelling for help. RN and PSW discovered a chunk of food in the resident's mouth while doing the emergency response procedure.

The resident's plan of care indicated they required specific assistance with one staff member when eating. The Registered Dietician (RD) verified that the resident's assessment related to their level of assistance was the same. Further, they indicated that the specific types of assistance included feeding the resident, reminding the resident to swallow while eating, cutting their food into small pieces, and sitting with them until the resident finished eating. PSW acknowledged that they did not assist the resident as to what type of assistance was indicated in the care plan but did monitor them from the nursing station. The DOC confirmed that the plan of care was not followed at the time of the incident.

By not ensuring the resident's care plan was followed while eating, the resident was placed at risk of choking.

Sources: CI, internal investigation documents, interviews with PSW, RD, and DOC, resident's care plan, RD assessment notes.

This order must be complied with by October 18, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE the Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect

to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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