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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Public Report

Report Issue Date: December 10, 2024

Inspection Number: 2024-1080-0002

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): December 2, 3, 5, 6, and 10, 2024 and offsite on December 4, and 9, 2024.

The following intake(s) were inspected:

- Seven intakes regarding allegations of resident to resident abuse.
- A Follow-up #1 regarding FLTCA, 2021, s. 6 (7) Plan of care in inspection #2024-1080-0001, with a CDD for October 18, 2024.
- Two intakes regarding allegations of staff to resident abuse.
- An intake regarding a facility wide Enterovirus outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1080-0001 related to FLTCA, 2021, s. 6 (7)

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

Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to protect a resident from emotional and physical abuse, when a Personal Support Worker (PSW) was rough with a resident and did not respect the resident's wishes.

“Emotional abuse” means any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation,

shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

"Physical abuse" means the use of physical force by anyone other than a resident that causes physical injury or pain.

The resident was upset and was found to have minor injuries following the incident. There were previous allegations of resident abuse for the PSW and disciplinary action was taken.

Sources: clinical records for the resident, Long-Term Care (LTC) home's internal investigation documents, interview with Executive Director (ED).

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 the Director was immediately informed of allegations by an agency Registered Nurse (RN) that a PSW failed to provide a resident with privacy during continence care and was being rough with the resident. The ED confirmed the RN did not immediately notify the Director of the allegations.

Sources: A CI, and interview with the ED.

WRITTEN NOTIFICATION: Responsive behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that the strategies to manage a resident's responsive behaviours were implemented. An agency RN documented allegations that a PSW failed to provide the resident with privacy during care and was being rough with the resident. The ED confirmed the interventions to manage the resident's responsive behaviours were not implemented.

Sources: A resident's care plan, progress notes, internal investigation notes, and an interview with the ED.

WRITTEN NOTIFICATION: Altercations and Other Interactions

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The licensee failed to ensure that steps were taken to minimize the risk of altercations between two residents when interventions were not implemented. A resident was found in a co-resident's room, and there was an altercation.

Both residents had identified responsive behaviours and interventions to prevent altercations and other incidents.

Sources: Clinical records for the residents, interviews with staff.