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

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Public Report

Report Issue Date: February 3, 2025
Inspection Number: 2025-1080-0001
Inspection Type: Critical Incident
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): January 27, 28, 30, 31, 2025 and February 3, 2025

The following intake(s) were inspected:
Intake: #00132221 - Critical Incident related to alleged abuse of residents by staff
Intake: #00136902 - Critical Incident related to alleged resident to resident abuse.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to ensure that the signage posted at entrances and throughout the home listed the signs and symptoms of infectious diseases for self-monitoring. On entry to the home, there was signage posted for passive screening that was exclusive to monitoring symptoms of coronavirus disease (COVID-19) and measles, and not additional types of infectious diseases.

The Infection Prevention and Control (IPAC) lead was made aware of the additional screening requirements in accordance with the "Infection Prevention and Control Standard for Long Term Care Homes" revised September 2023 (IPAC Standard), Additional Requirement 11.6. On a later date, the posted signage was removed and replaced with new signage that indicated symptom self-monitoring for respiratory, enteric, ocular diseases, and other communicable diseases.

Sources: observations, and interview with the IPAC lead

Date Remedy Implemented: January 30, 2025

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

The licensee has failed to ensure that the staff and others involved in the different aspects of care collaborated with each other in the review of a resident's lab report.

A Registered Nurse (RN) and the Director of Care (DOC) indicated that the lab results were not conclusive and that they should re-attempt another lab collection for analysis. Another RN and the DOC both indicated that the lab reports are all reviewed by the nurse practitioner or the physician, however there was no documented review of the report. The DOC indicated that the review process was likely missed. Failure to ensure that staff and others involved in different aspects of care for the resident were kept informed of test results can impact timely care.

Sources: the resident's clinical records and interview with RN staff and the DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a

risk of harm to the resident.

The licensee failed to ensure that an alleged incident of improper care of a resident that resulted in risk of harm to the resident was immediately reported to the Director. An RN received a complaint from a Personal Support Worker (PSW) that alleged improper transfer and positioning of a resident by staff that resulted in a risk to cause harm. This incident was not reported to the Director until a later date.

Sources: Critical incident report, home's investigation notes, interview with a PSW and the DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #004 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 alleged abuse of residents was immediately reported to the Director. A PSW reported to the Executive Director (ED) that they previously witnessed incidents of alleged abuse of residents by another staff member. Failure to immediately report suspicion, or witnessed abuse of residents to the Director placed them at risk of harm.

Sources: Critical incident report, home's investigation notes, interview with a PSW and the DOC.