Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspection Branch

London District Office
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775
londonsao.moh@ontario.ca

Amended Public Report A1

Report Issue Date: November 30, 2022

Inspection Number: 2022-1037-0002

Inspection Type:
Follow up
Critical Incident System

Licensee: CVH (No. 8) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes

Long Term Care Home and City: Seaforth Long Term Care Home, Seaforth

Inspector Who Amended	**Inspector Who Amended Digital Signature**
Tatiana Pyper (733564)	Tatiana Pyper Digitally signed by Tatiana Pyper Date: 2022.11.30 11:51:48 -05'00'

Additional Inspector(s)
Ali Nasser (523)

AMENDED INSPECTION REPORT SUMMARY

An administrative change to the inspection report is required. There is no change to the narrative of the finding(s)/ground(s) or the determination of compliance.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 24, 2022
October 25, 2022
October 26, 2022

The following intake(s) were inspected:
- Intake: #00002259 (CIS #1135-000004-22) related to staff to resident neglect.
- Intake: #00007027 (CIS # 1135-000007-22) related to falls prevention.

- Intake: #00007665- Follow up to Compliance Order #001 from Inspection #2022_1037_0001, related to s. 19 (1), neglect, with a Compliance Due Date of September 9, 2022.

Previously Issued Compliance Order(s)

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

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
LTCHA, 2007 S.O. 2007, c.8	s. 19 (1)	2022-1037-0001	#001	(523)

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

Infection Prevention and Control
Falls Prevention and Management
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee has failed to ensure that Seaforth Long-Term Care home's policy to promote zero tolerance of abuse and neglect of residents was complied with by a specific PSW.

Rationale and Summary
The home submitted a Critical Incident System (CIS) report. The CIS report stated that on a

specific date, a resident's call bell was malfunctioning, and the resident was provided with a tab alarm to use to call for assistance. At the beginning of the night shift on a specific date, the resident had activated the alarm. A PSW responded to the alarm, and then had taken it away from the resident. When the PSW was leaving the room, the resident had asked to have the alarm returned to them. The PSW refused to return the alarm to the resident, and then told them that they will never see it again. The resident did not have the means to call for assistance for the remainder of the shift.

In an interview with Director of Care (DOC), they said the call bell for the resident was malfunctioning on a specific date, and the resident was provided with a clip alarm to call for assistance. DOC stated that on that specific date, they were informed that the resident reported the allegations of staff to resident neglect to a PSW on a specific date, but they did not become aware of the incident until the next day.

A review of the Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy RC-02-01-02, last reviewed January 2022, under reporting, stated, “Any employee or person who becomes aware of an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior supervisor on shift at that time."

DOC stated that the home’s policy required any staff members to immediately report any allegations of abuse or neglect. DOC stated that the PSW did not comply with the Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy RC-02-01-02 policy when they did not report the allegations of the alleged neglect.

Sources: Critical Incident 1135-000004-22, review of Seaforth LTCH's Zero Tolerance of Resident Abuse and Neglect: Response and Reporting policy RC-02-01-02, last reviewed January 2022 and staff interviews.

[523]

WRITTEN NOTIFICATION: Falls Prevention and Management Program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 53 (1) 1.

The licensee has failed to comply with the Falls Prevention and Management Program in the home for the Head Injury Routine (HIR) for a resident.

In accordance with O. Reg 246/22 s. 11. (1) b, the licensee was required to ensure the Falls Prevention and Management Program was complied with, as a part of the licensee's Falls Prevention and Management Program.

Specifically, staff did not comply with the licensee's Head Injury Policy RC-15-01-01, last reviewed January 2022, which was part of the licensee's Falls Prevention and Management Program.

Rationale and Summary
A resident had an unwitnessed fall on a specific date, requiring HIR. The HIR documentation was not completed for several of the indicated times required.

The resident had an unwitnessed fall on another date, requiring HIR. The HIR documentation was not completed for several of the indicated times as required.

Director of Care (DOC) indicated that the HIR for the resident was not completed according to the home's Falls Prevention and Management policy.
There was risk to the resident when they were not neurologically assessed after having unwitnessed falls.

Sources: review of resident's clinical records, review of Seaforth LTCH Neurological Signs/Head Injury Routine RC-25-01-38, last reviewed January 2022, and interview with Director of Care.

[733564]