Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Nov 19, 2021	2021_946111_0005	015146-21, 016553-21	Complaint

Licensee/Titulaire de permis

CVH (No. 6) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

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

Hope Street Terrace
20 Hope Street South Port Hope ON L1A 2M8

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 14, 18 to 20, 2021.

There were two inspections completed concurrently during this inspection:
-complaint related to alleged staff to resident abuse.
-Critical incident report (CIS) for an alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, a Registered Nurse (RN) and a resident.

During the course of the inspection, the inspector(s): reviewed the residents health record, the home's investigation, staff schedules, employee records and the home's zero tolerance of resident abuse and neglect.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Any staff being notified of an alleged abuse, were to complete a full assessment of the resident to determine the resident's needs, provide support to the abused resident and then document the assessment. All reported incidents of abuse were to be objectively, thoroughly and promptly investigated and at the conclusion of the investigation, a determination made based on the facts of the case on the best course of action to prevent future incidents of abuse. When the allegations of abuse were made against an employee, the management were to immediately advise the employee that they were being removed from work pending the investigation and the employee was to be contacted directly to arrange for an interview.

An RN received a complaint from a resident alleging staff to resident abuse, involving PSW #100 and the incident had occurred the previous day. The RN confirmed the PSW was working when the allegation was received and they did not relieve the PSW of duty pending the investigation, as per the policy. The RN confirmed they did not document an assessment of the resident related to the allegations, as per the policy, but had reported the allegation to the Administrator the same day. A number of weeks later, the Administration continued the investigation, after the Inspector arrived at the home. A number of days later, the resident reported a second alleged staff to resident abuse incident involving the same PSW. The resident remained upset regarding both incidents. The Administrator indicated they became aware of the initial alleged staff to resident abuse a number of days later. The Administrator indicated they were unable to thoroughly investigate the allegation until a number of weeks later due to the PSW being on leave, despite the PSW working the day the Administrator indicated they received the allegation and a number of days following the allegation. The Administrator confirmed they received a second complaint from the resident regarding alleged staff to resident abuse, involving the same PSW and the staff member was not relieved of duty pending the investigation, as per the home's policy. Failing to follow the home's zero tolerance of abuse and neglect policy led to a second incident of staff to resident abuse.

Sources: review of a resident's health record, the home's investigation, zero tolerance of abuse and neglect policy, interview of the resident and staff.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with, to be implemented voluntarily.

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 :

The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by a staff member, that resulted in harm or risk of harm, immediately reported the suspicion and the information upon which it was based to the Director.

A resident reported an alleged staff to resident abuse incident involving a PSW, to an RN. The RN confirmed they had not reported the allegation to the Director, had reported the allegation to the Administrator. The Administrator confirmed they did not report the allegation to the Director.

Sources: review of the home's investigation and interview with staff.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged staff to resident abuse, that the licensee suspects may constitute a criminal offence.

A resident reported an alleged staff to resident abuse incident to an RN. The RN confirmed they did not report the alleged abuse to the police but notified the Administrator. The Administrator confirmed that they did not report the allegation to the police. Failing to report alleged staff to resident abuse to the appropriate police force may lead to further abuse of residents.

Sources: review of the home's investigation and interviews of a resident and staff.

Issued on this 22nd day of November, 2021

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

Original report signed by the inspector.