Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 5, 2015 | 2015_195166_0008 | 00474-13, 00489-13, 000502-13, 00795-13, 00853-13, 00921-13, 001215-14, 001218-14, 001304-14, 001866-15 | Critical Incident System |

### Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Port Perry Place
15941 Simcoe Street Port Perry ON L9L 1N5

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

CAROLINE TOMPKINS (166)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): April 22, 23, 24, 27, 28, 29, 2015**

**Complaint Logs #O-000795-13 ,#O-00921-13, #O-001218-14, #O-001304-14, #O-001866-15 and Critical Incident Logs, #O-000474-13, #O-000502-13, #O-000853-13, #O-000489-14, #O-001215-14, were inspected concurrently.**

**During the course of the inspection, the inspector(s) spoke with Residents, Family members, Administrator, Director of Care, RAI Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeeping staff, Physiotherapy Assistants, Behaviourial Support staff(BSO), Occupational Therapist and Behaviourial Therapist.**

**During the course of this inspection, the inspectors reviewed clinical records, the licensee's investigation documentation, observed staff to resident interactions during the provision of care, observed resident to resident interactions and medication administration and documentation.**

**The following Inspection Protocols were used during this inspection:**
**Critical Incident Response**
**Dignity, Choice and Privacy**
**Falls Prevention**
**Medication**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**
- **5 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 23. Licensee must investigate, respond and act**

**Specifically failed to comply with the following:**

**s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the results of an neglect investigation was reported to the Director.

A Critical Incident(CI) was received by the Director reporting an incident of staff to resident neglect.
Review of the documentation indicated that the Director of Care received a letter from PSW #105 alleging that on specified date, PSW #104 did not get Resident #9 up for a meal and did not provide the resident with a tray.

Interview with PSW# 105, indicated that on a specified date, Resident #9 did not come to the dining room and the dietary staff set a tray up to be taken to the resident.

When PSW #105 brought Resident #9 to the dining room at a later time the same date, the resident indicated he/she was very hungry. PSW #105 asked if he/she had received a tray, the resident indicated he/she had not.

Review of the licensee's investigation indicated the Dietary Aide( DA) had prepared trays for all the residents who had not come to the dining room and all the trays but the tray for Resident #9 had been delivered.

Review of the the licensee's interview with Resident #9 indicated the resident was not able to remember the date or recognize the staff but did recall not being awakened for the meal.

The results of the investigation were not reported to the Director. [s. 23. (2)]

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

1. Log O-000474-13

The licensee has failed to ensure that staff used a safe positioning device when assisting/ monitoring Resident #1 when resident was in his/her wheelchair.

A Critical Incident Report (CIR) was received indicating that Resident #1 had fallen from his/her wheelchair. The resident was transferred to the hospital for further assessment and treatment.

The plan of care for Resident #1, identifies the resident as a high risk falls for falls and interventions for safety included the use of a seat belt alarm.

Review of clinical documentation and interview with the RAI/Education Coordinator (who was present at the time of the incident) indicated the seat belt alarm was not functioning at the time of the incident as there was no battery in the unit. [s. 36.]

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

**Specifically failed to comply with the following:**

**s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:**
**1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).**

**s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,**
**(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).**
**(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).**
**(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).**
**(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).**
**(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).**
**(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).**

**Findings/Faits saillants :**

1. Log O-000921-13

The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint and where the complaint alleges harm or risk of harm to one or more residents, the investigation commenced immediately.

A complaint related to medication administration, specifically related to times of the administration of medication for Resident #4 was received by the Director.
The resident's family member indicated that prior to submitting the concern to the Director, the family member had made two verbal complaints to the Director of Care relating to medication administration for Resident #4.

Review of the complaint, alleged that RN #114 was not administering Resident #4's medications timely and that sometimes the medications were doubled up or not given at all.
The complaint alleged that all the residents in the same home area did not get their medications all the time, but it is documented that the medications have been given.

Interview with the Director of Care indicated the date the first verbal complaint was received, the Director of Care met with the family member.

The Director of Care indicated the family member did not feel the concern was resolved and met with the family member five days later. The Director of Care indicated she would request the physician change the medication administration times for Resident #4.

Review of physician's orders indicated the medication administration times for Resident #4 had been changed.

Interview with the Director of Care indicated a review of the medication administration times for Resident #4 and an review of the medication administration procedure including documentation was conducted in the home area. The Director of Care indicated a response to the complaint was not provided to the family.

Interview with Resident #4's Power of Attorney indicated that the family did not receive a response to their complaint. [s. 101. (1) 1.]

2. Log O-000921-13

The licensee has failed to ensure that that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant.

Interview with the Director of Care and the present Administrator indicated that at the time that this complaint was brought forward no documented record of this specific complaint was kept. [s. 101. (2)]

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act**

**Specifically failed to comply with the following:**

**s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:**
**1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).**

**Findings/Faits saillants :**

1. Log O-001215-14

The licensee in making a report to the Director under subsection 23 (2) of the Act, failed to include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: 1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

A Critical Incident Report(CIR was received by the Director reporting an alleged incident of staff to resident neglect.

The CIR documentation indicated that PSW #104 delivered a letter to the Director of Care. The letter indicated allegations of abuse/neglect of residents by PSW #105. There was no further description in the report.

The report does not identify type of abuse incident, area or location of the incident, date and time of the incident and events leading up to the incident. [s. 104. (1) 1.]

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

**Specifically failed to comply with the following:**

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).**
**2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,**
**i. a breakdown or failure of the security system,**
**ii. a breakdown of major equipment or a system in the home,**
**iii. a loss of essential services, or**
**iv. flooding.**
**O. Reg. 79/10, s. 107 (3).**
**3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**
**4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**
**5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

1. Log O-000489-14

The licensee has failed to ensure that the Director is informed no later than one business day after the occurrence of the incident  of resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

A Critical Incident Report (CIR) was received by the Director reporting that Resident #6 was found outside the main doors of the home.

Review of the CIR, Resident #6's clinical records, interview with the Director of Care and a Registered staff, who works in the resident's home area indicated the resident was observed by staff exiting the main doors of the home. The resident was immediately brought back into the home, there was no injury or adverse change in the resident's condition.

The door security system at the main doors and within the home were checked by a service company and all doors were found to be in good working order.

The incident was not reported to the Director until 15 days post incident. [s. 107. (3)]

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**Issued on this 5th day of June, 2015**

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

**Original report signed by the inspector.**