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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 27, 2015	2015_195166_0015	O-001333-14, O-002355-15, O-001644-15, O-002050-15	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): July 6, 7, 2015

Complaint Log O-002355-15 and Critical Incident Log O-001644-15 and O-002050-15 were inspected concurrently.

During the course of the inspection, the inspector(s) spoke with Family(Power of Attorney),Resident #3, Director of Care, Administrator, Program Manager, Staffing Manager and Personal Support Workers.
During the course of the inspection, the inspector reviewed the clinical health records for Resident #1 and Resident #4, reviewed the licensee's investigation documentation, the licensee's policy related to staff to resident abuse, medication incident records and staffing schedule for Registered staff

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **5 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	Legendé 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 :

1. O-002050-15

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

The licensee's Resident Abuse -Staff to Resident, Policy Reference #OPER_02-02-04, directs staff to immediately report (verbally) any suspected or witnessed abuse to Administrator,Director of Care or their designate (e.g,supervisor,department head)who report the incident, as required by provincial legislation and jurisdictional requirements.

Critical Incident Report(CIR) was received by the Director indicating that on a specified date, Resident #2, reported to a family member that they had heard Resident #1(co-resident) being slapped by a staff, who was providing care to Resident #1.
Resident #2, told the family member they did not see anything, but heard a slap noise and called out to the staff and the staff responded that the resident was not slapped.
The family member reported the conversation to a member of the Registered staff member two days post incident.
Review of the licensee's investigation and interview with the Director of Care and Administrator indicated the Registered staff member did not inform the Charge nurse of the allegations of staff to resident physical abuse.
An unsigned note reporting the allegations of staff to resident abuse was received by the Administrator 3 days post incident. [s. 20. (1)]

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 licensee's policy that promotes zero tolerance of abuse and neglect is complied with, specifically related to mandating staff to immediately report (verbally) any suspected or witnessed abuse to Administrator, Director of Care or their designate, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. O-002050-15

The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:

A Critical Incident (CIR) was received indicating that on a specified date, Resident #2, reported to a family member, they had heard Resident #1 being slapped by a staff, while the staff was providing care to Resident #1.
Resident #2, told the family member that they did not see anything, but when they heard a slap noise called out to staff and the staff responded that the resident was not slapped.
The family member reported the conversation to a member of the Registered staff two days post incident.

Clinical documentation indicates the Registered staff member, assessed and interviewed the resident, Resident #1 was unable to recall if an incident had occurred and did not have any reddened or bruised areas. Resident #1 denied any pain or discomfort.

Review of the licensee's documentation indicated the licensee did not initiate the investigation into the alleged staff to resident physical abuse until 6 days post incident, when the licensee interviewed Resident #2. Resident #1 was interviewed 17 days post incident, subsequent interviews with staff occurred 11 and 18 days post incident. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. O-002050-15

The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.
Review of the CIR, clinical documentation, the licensee's investigation and interview with the Administrator indicated that the resident's SDM was not notified of the results of the investigation immediately upon completion. [s. 97. (2)]

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:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. O-002050-15

The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident : names any staff members or other persons who were present at or discovered the incident.

Review of the CIR did not include the name of the the staff member, involved in the alleged incident of staff to resident physical abuse. [s. 104. (1) 2.]

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-001644-15

The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of the incident of:
an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

On a specified date and time, Resident #4 was found sitting on the floor by the bedside, calling for help. The resident was transferred to the hospital for further assessment.

The resident returned from the hospital, with limited mobility and required extensive assistance with care and toileting.

Prior to the incident Resident #4 was ambulatory with a walker, was continent of bowel and bladder and was able to self toilet.

The Director was not notified of the occurrence that resulted in a significant change in Resident #4's health condition and for which the resident is taken to a hospital until 2 days post incident. [s. 107. (3)]

Issued on this 27th day of July, 2015

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

Original report signed by the inspector.