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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 12, 2017	2017_623626_0014	017499-17, 017724-17	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

DENISE BROWN (626)

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): August 25, 28, 29, 30, 31 and September 1, 2017. On September 8, 2017, off site interviews were conducted.

The following Critical Incident intake logs were inspected during the course of the inspection:

Intake Log #017724-17: Related to staff to resident neglect associated with a fall
Intake Log #017499-17: Related to an alleged resident to resident sexual abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (DOC), MDS-RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and family members.

During the inspection, the Inspector observed staff to resident interaction and the provision of care. The Inspector also reviewed residents' health records, internal related investigations and applicable policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, related to responsive behaviours.

Related to Intake #017499-17:

A Critical Incident Report was submitted to the Director on a specified date, regarding an alleged incident of resident to resident sexual abuse. The incident involved resident #003 and #004.

A review of the written plan of care for resident #003 and #004 indicated that both resident were to be kept apart.

During the inspection on a specified date, Inspector #626 observed resident #003 and #004 seated at a table together.

In an interview on a specified date, RPN #108 indicated that the residents were to be kept apart. In another interview on separate specified dates, PSW #116 and the DOC both indicated, that the residents were to be kept apart.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. Resident #004 was seated beside resident #003, when they should have been kept apart. [s. 6. (7)]

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, related to falls.

Related to Intake #017724-17:

A Critical Incident Report (CIR) was submitted to the Director on a specified date, regarding an alleged staff to resident neglect. The CIR indicated an allegation of neglect by a PSW towards resident #001 after a fall. The CIR was submitted to the Director by the home after receiving a related verbal and written complaint.

A review of resident #001's written plan of care, indicated interventions for fall prevention including ensuring that the identified alarming device was activated when it was applied to the resident.

During an interview on a specified date, RN #109 indicated, that the alarming device was not activated on the specified date that the fall occurred. In two interviews on separate specified dates, PSW #110, #113 and 129, all indicated that the alarming device for resident #001, must be activated when applied.

The Administrator indicated in an interview on a specified date that staff must ensure that the alarm of the identified device is activated when it is applied.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan by not ensuring that the alarm of the identified device was activated, when it was applied to the resident. [s. 6. (7)]

Issued on this 15th day of September, 2017

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

Original report signed by the inspector.