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
Jan 10, 2018	2017_594624_0032	021609-17, 021712-17	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

BAIYE OROCK (624)

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): December 27 and 28, 2017

The following logs were inspected concurrently:
Log # 02160609-17 related to a submitted Critical Incident Report about the fall of a resident with injury, and
Log # 021712-17 related to a complaint from a family member about falls management.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), a Long-Term Care (LTC) Consultant, a Registered Nurse (RN), Personal Support Workers (PSWs) and a family member.

A tour of the home was completed, several observation of staff to resident interaction during the provision of care. A review was also completed of the residents' health records, the licensee's internal investigation notes, as well as relevant policies and procedures related to falls management.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to comply with its Falls Prevention and Management Program" policy # RC-06-04-01.

As per Ontario Regulations (O. Reg) 79/10, s. 48 (1). 1, every licensee of a long-term care home shall ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury, is developed and implemented in the home.

As per the Licensee's "Falls Prevention and Management Program" policy # RC-06-04-01, last updated in May of 2016, under post fall assessment section (page 4 of 9) it states:
"POA/SDM/Family/Physician/NP and management should be notified as required" and "Communicate with POA/SDM/family per care plan/documented preferences."

Related to a Critical Incident Report and a complaint log #021712-17,

A Critical Incident Report (CIR) was submitted to the Director on a specified date about the fall of resident #001 on an identified date and time, for which the resident was taken to hospital, resulting in a significant change in the resident's condition. A complaint was also made to the Director three days after the incident by the resident's Substitute Decision Maker (SDM) related to the licensee's management of the fall incident involving resident #001.

Resident #001 was admitted to the home on an identified day with specified diagnoses. On an identified date, resident #001 sustained an unwitnessed fall. According to post fall assessment completed at a specified time by the RN on duty at the time of the fall, the resident complained of pain to an identified body part and was administered analgesics. The same progress note also indicated that POA/MD will be notified promptly while another progress note written on the same day of the fall, indicated that a message was left for the SDM approximately three hours after the fall, to call the home for updates.

In an interview with resident #001's SDM on an identified date, the SDM indicated that upon admission, the home had been informed that the SDM should be called at all times for any updates regarding the resident. The SDM indicated that it took more than four hours after the incident to be notified of the fall. A review of resident 001's health records revealed documentation that the SDM wanted to be called at all times for updates.

The RN who had written the progress note regarding the incident, was not available for interview during the inspection. An interview was conducted on an identified date with RN #101 who was the acting Director of Care (DOC) at the time of the incident. Long-Term Care (LTC) Consultant #102, who was sitting in for the current DOC, was also present during the interview. Related to the incident, they both indicated that the licensee's expectation according to the falls prevention and management policy is for residents' family or SDMs to be notified based on their stated preferences. In the case of this fall incident, both staff indicated that the resident's SDM was not notified based on the SDM's documented preference as noted in the resident's health records.

The licensee failed to comply with its falls policy by not notifying the SDM of resident #001 based on the SDM's documented preference. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 10th day of January, 2018

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

Original report signed by the inspector.