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
Oct 2, 2020	2020_523461_0007	000967-20	Critical Incident System

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

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

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

CRISTINA MONTOYA (461)

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): September 9, 10, 15, 16 and 17, 2020.

An off-site inspection was completed for a log related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Activity Director, Registered Practical Nurse (RPN), Registered Dietitian (RD), and Personal Support Workers (PSWs).

During the course of the inspection, the inspector reviewed the following: the resident's health care records, internal abuse investigation documentation, and relevant polices.

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

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 plan of care set out clear directions to staff related to the diet texture provided to a resident.

The resident's diet order included a diet with a modified food texture. The written plan of care did not specify for the staff the resident's type of food texture and the level of eating assistance. A Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) reported that the resident was receiving a different food texture from the diet order. On one occasion, the RPN observed an Activity Aide feeding the wrong food texture to the resident while using inappropriate feeding techniques. The lack of clear directions for the staff related to the food texture and level of eating assistance placed the resident at risk of harm.

The Registered Dietitian (RD) acknowledged that the diet order was not updated in the written plan of care for the staff.

Sources: the resident's electronic health records, home's internal investigation, interview with he RPN, the PSW, the RD and other staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care for a resident related to the diet order was provided.

The resident's diet order included a modified food texture and a nutritional supplement. A PSW and a RPN observed an Activity Aide modifying the resident's food texture and supplement's consistency without a direction from the RPN or the RD. The staff member’s actions increased the likelihood of harm to the resident.

The Executive Director (ED) acknowledged that the staff member did not follow the plan of care by modifying the resident's food texture without informing any supervisory staff or the RD.

Sources: the resident's plan of care and health records, home’s internal investigation, interview with the ED, a RPN, a PSW, and RD. [s. 6. (7)]

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, and that the care set out is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure proper techniques to assist a resident with eating and safe positioning.

A PSW observed an Activity Aide feeding a resident even though the resident displayed non-verbal signs of disinterest in the meal. Although the resident's plan of care did not specify the level of eating assistance, a PSW and a RPN reported it was clear that the resident did not want to eat and looked uncomfortable.

The ED and Activity Director acknowledged that the alleged staff member did not follow proper techniques to feed the resident and continued feeding the resident despite displaying lack of interest in eating.

Sources: critical incident system (CIS) report, home’s internal investigation, interview with PSW, RPN, RD, ED and other staff. [s. 73. (1) 10.]

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 proper techniques to assist residents with eating, including safe positioning of residents who require assistance, 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. The licensee has failed to ensure that a resident's Substitute Decision-Maker (SDM) was notified of the results of the alleged abuse investigation immediately upon its completion.

On one occasion, a RPN observed a staff member feeding a resident against their wishes. The allegation of abuse was investigated and determined to be founded. The ED was unable to verify if the outcomes of the investigation were communicated to the resident's SDM.

Sources: home's internal investigation and an interview with the ED, RPN and other staff. [s. 97. (2)]

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 resident's substitute decision-maker are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation, to be implemented voluntarily.

Issued on this 6th day of October, 2020

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

Original report signed by the inspector.