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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 31, 2022	2022_875501_0005	013390-21, 015645-21, 018791-21, 020861-21, 000487-22, 000673-22	Complaint

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

SUSAN SEMEREDY (501), ERIC TANG (529)

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): March 23, 24, 25, 28, 29, 2022.

During the course of this inspection the following complaint intakes were inspected:

Log #000673-22 related to dignity, choice and privacy;
Log #020861-21 related to infection prevention and control (IPAC), sufficient staffing, and dignity, choice and privacy;
Log #000487-22 related to dining, food quality and housekeeping;
Log #018791-21 related to personal support services and sufficient staffing;
Log # 013390-21 related to sufficient staffing, continence care, personal support services and maintenance; and,
Log # 013390-21 related to maintenance.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Regional IPAC Lead, Environmental Manager, Nutrition Care Manager, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), COVID-19 Screener, Dietary Aide, Housekeeper, substitute decision-makers and residents.

During the course of the inspection, the inspectors observed resident and staff interactions, the provision of care, dining and IPAC practices. The inspectors reviewed clinical health records, relevant home policies and procedures, menus and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Food Quality
Infection Prevention and Control
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

- **3 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	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).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's written plan of care provided clear direction to staff.

The resident's written plan of care directed staff to assist a resident with an activity of daily living (ADL) in a specific manner. Observations and interviews indicated direct care staff were not assisting the resident with this ADL as written in the plan of care. The DOC confirmed that changes had been made and as a result the written plan of care did not provide clear direction.

Failing to provide clear direction in the resident's written plan of care put the resident at risk to receive improper care.

Sources: A resident's electronic health records including written plan of care, observations, and staff interviews. [s. 6. (1) (c)]

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 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure menu items were prepared according to the planned menu.

It was observed in a dining room that strawberries were being offered for dessert for those on a regular textured diet according to the planned menu . However, crushed pineapple was available for those on a minced diet and pureed pineapple was available for those on a pureed diet. A sample of the pureed pineapple indicated it was not smooth and had chunks. An interview with a staff member indicated there was not enough strawberries to offer to those on minced and pureed diets and hence pineapple was used as a substitution. A review of the therapeutic menus indicated that when crushed pineapple is on the menu, those on puree are to receive applesauce. An interview with the Nutrition Care Manager confirmed that when crushed pineapple is being served, applesauce should be served to those on a pureed diet because pineapple is impossible to puree.

There was an increased choking risk to those receiving pureed pineapple as it was not prepared according to the planned menu.

Sources: Observation, review of the home’s menus and interviews with the Nutrition Care Manager and other staff. [s. 72. (2) (d)]

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 menu items are prepared according to the planned menu, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items were available.

An interview with a resident indicated that often the food served at the home was unappetizing and as an example they stated that at meal that day there was not a condiment available. The resident stated that it may not seem like much, but it means a great deal to them. A review of the planned menu indicated this condiment was to be served. An interview with the Nutrition Care Manager confirmed that this menu item was not available due to an ordering error.

As a result of an ordering error, a planned menu item was unavailable which made the meal unappetizing.

Sources: Review of the home's planned menu and interviews with a resident and the Nutrition Care Manager. [s. 71. (4)]

Issued on this 1st day of April, 2022

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

Original report signed by the inspector.