Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
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Original Public Report

Report Issue Date: June 16, 2023
Inspection Number: 2023-1080-0003
Inspection Type: Complaint Critical Incident System
Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partner)
Long Term Care Home and City: Regency Long Term Care Home, Port Hope

Lead Inspector	**Inspector Digital Signature**
Rita Lajoie (741754)	Rita Lajoie Digitally signed by Rita Lajoie Date: 2023.06.22 11:57:16 -04'00'

Additional Inspector(s)
Chantal Lafreniere (194)
Susan Somerville (744441)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 29 - 31, 2023 and June 1, 2, 5 - 9, 2023
The inspection occurred offsite on the following date: June 7, 2023

The following intake(s) were inspected:

- Complaints related to maintenance and housekeeping
- Complaint related to resident care issues
- Critical Incidents related to fall of a resident
- Critical Incident related to resident to resident abuse
- Critical Incident related to injury of unknown cause

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 3 (1) 12.

The licensee failed to ensure that every resident had the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

Rationale and Summary:

Administrator confirmed that there were two outdoor areas in the home accessible to the residents. On the first floor, one outdoor area which led to the parking lot and roadway was unprotected. The second outdoor area was the back courtyard which was fenced.

On May 30, 2023, the back courtyard outdoor area was observed by the inspectors. Inspectors toured the courtyard and noted that it was in disrepair, with overgrown vegetation, three sections of the fence broken, debris on the walkway and a fountain with water that was not operational and dirty.

The Administrator and Maintenance person confirmed that three sections of the fence for the back courtyard was blown down over the winter. The Maintenance person stated that they were currently working on fixing the fence. They also confirmed that a landscaping company had been asked to submit

a quote for weeding, pruning, mulch and tree trimming in the back courtyard.

Failing to ensure that residents are given access to protected outdoor areas in order to enjoy outdoor activity, decreases the resident's enjoyment of their home.

On June 1, 2023, it was observed that the back courtyard fencing had been repaired and was secure for the residents to access. Most of the vegetation had been trimmed but remained to be removed from the area.

Sources: Observation of outdoor space, interview with staff (care staff, Administrator and Maintenance)

Date Remedy Implemented: June 1, 2023 [194]

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of resident #001 and on their needs and preferences related to their bedtime routine and their personal relationships.

Rationale and Summary:

A complaint was received by the Director from a family member for resident #001 expressing concerns related to resident #001's personal care.

Review of the progress notes indicated that resident #001 had developed a relationship with resident #007. Both residents are assessed to have mild cognitive impairment. Documentation in the progress notes demonstrated that the resident displayed an ongoing desire to continue the relationship and would become aggressive and resistant to receiving bedtime (HS) care.

Interviews with care staff indicated that the resident preferred to spend their evenings with resident #007.

The resident's physician and the Director of Care (DOC) determined that the resident was competent to make their own decision about refusing HS care. The care plan was not updated to reflect the resident's preferences relating to provision of HS care.

Failing to ensure that the written plan of care was updated regarding changes to the resident's bedtime routine preferences, the resident's choice to have a relationship and how to manage their care, placed them at risk of harm as staff were not providing consistent strategies to meet her needs.

Sources: Observations of resident, review of progress notes, care plans, and RAI / MDS documentation, interviews with resident and staff (PSW #112, #113. #106, RN #115, RAI Coordinator, DOC) [741754]

WRITTEN NOTIFICATION: ACCOMMODATION SERVICES

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)

The home failed to ensure that the bathroom flooring, vanity, and walls in three resident rooms, wall damage in two resident rooms, and ceiling damage in one resident room, were maintained in a safe condition and in a good state of repair.

Rationale and Summary:

An anonymous complaint was received by the Director from a resident expressing concerns related to housekeeping and maintenance.

One resident bathroom was observed to have cracked flooring around the toilet, the floor had imbedded dirt behind the toilet and under the sink. The wooden framing around the sink was damaged and the sink required caulking. Water damage on the ceiling tiles in the bathroom was observed, there was a hole in the ceiling by the bed and the bedroom walls very scuffed and needed to be painted. The damage to the wall, flooring and sink area could not have been properly disinfected when cleaning.

In another resident bathroom flooring was observed to have imbedded dirt. Housekeeper #107 confirmed that the stains on the floor did not come off. The wooden framing around the sink was chipped, the door frame vinyl protector strip was cracked and chipped and there was a hole in the wall under the sink. The damage to the bathroom would have prevented the home from proper disinfection when cleaning and presented a potential for injury on the chipped and cracked surfaces around the door.

Another resident room was observed to have two patches on the ceiling, which were not painted. There was water damage to ceiling near the window. There was wall damage, with multiple plugs in the wall from pervious items removed, filling and painting was required. There were holes noted in the ceiling above the beds. The bathroom walls were scuffed and observed to need painting. There was

discoloration noted on the floor around the toilet, flooring was lifting behind the toilet and the molding around the base of the wall was lifting and coming away from the wall under the sink. The damage to the rooms and bathroom would have prevented the home from proper disinfecting when cleaning.

Another resident room was observed to have ceiling damage under the light in center of the room. The area could pose an electrical hazard if not repaired.

During the tour of the home, ceiling damage to five rooms on the first floor was observed, where drywall patching had been completed, but not sanded or repainted. The surfaces could not be disinfected when cleaned.

Maintenance person, Administrator and Environmental Service Supervisor (ESS) confirmed that repairs to the identified rooms were required.

Failing to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, places the resident at an increased risk of infection and injury.

Sources: observation of resident rooms, and interview with staff. (Administrator, Environmental Service Supervisor, Maintenance person and Housekeeper #107) [194]