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
Telephone: (844) 231-5702

Public Report

Report Issue Date: March 25, 2025
Inspection Number: 2025-1147-0002
Inspection Type: Critical Incident
Licensee: CVH (No. 6) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)
Long Term Care Home and City: Hope Street Terrace, Port Hope

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 19-21, 24-25, 2025

The following intake(s) were inspected:

Intake 00138405, Critical Incident Report (CIR) regarding an outbreak of infectious disease.
Intake 00140503, CIR regarding improper care of a resident.
Intake 00141313, CIR regarding an outbreak of infectious disease.

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

Infection Prevention and Control
Staffing, Training and Care Standards
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)
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee failed to ensure that the home was a safe and secure environment for its residents when the salon room was unsupervised and accessible. The contents within the salon room included a hazardous material. The Resident Assessment Instrument (RAI) coordinator locked the door immediately when made aware. The Executive Director indicated that they will ensure that the salon will be locked when not in use.

Sources: initial tour observation, interviews with Executive Director and RAI coordinator.

Date Remedy Implemented: March 19, 2025

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe

transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a Personal Support Worker (PSW) provided a resident, assistance for care and specific mobility as specified in the plan of care. The resident's safety was at risk when the PSW used improper positioning technique, causing the resident to fall and sustain an injury. The Director of Care (DOC) confirmed the plan of care was not followed by the PSW when assisting the resident.

Sources: Critical Incident Report (CIR), clinical records, investigation notes, interview with the DOC.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

1) The licensee failed to ensure that the Infection Prevention and Control (IPAC) standard for Long-Term Care Homes issued by the Director was complied with. In accordance with Additional Requirement 4.3 under the IPAC Standard for Long-Term Care Homes (April 2022; last revised September 2023). Specifically a summary of the findings and recommendations to the licensee for improvements to manage outbreak practices was not documented for the February 20, 2025, post outbreak debrief.

The IPAC lead confirmed the post-outbreak debrief was reviewed by the outbreak

management team (OMT) and interdisciplinary team however the summary of the findings regarding effectiveness of the interventions and recommendations to the licensee was not documented and completed regarding the improvement to manage outbreak practices.

Sources: CIR, Post outbreak debrief, and interview with the IPAC lead.

2) The licensee failed to ensure that the IPAC Standard for Long-Term Care Homes issued by the Director was complied with. In accordance with Additional Requirement 4.3 under the IPAC Standard for Long-Term Care Homes (April 2022; last revised September 2023). Specifically a summary of the findings and recommendations to the licensee for improvements to manage outbreak practices was not documented for the March 18, 2025 post outbreak debrief.

The IPAC lead confirmed the post-outbreak debrief was reviewed by the OMT and interdisciplinary team however the summary of the findings regarding effectiveness of the interventions and recommendations to the licensee was not documented and completed regarding the improvement to manage outbreak practices.

Sources: CIR, Post outbreak debrief, and interview with the IPAC lead.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act,

communication plans, and protocols for receiving and responding to health alerts; and

The licensee failed to ensure that a disease of public health significance was reported to the health unit immediately during an outbreak of respiratory infection on February 28, 2025.

In accordance with O. Reg. 246/22 section 11 (1) (b), the licensee is required to ensure that there are in place, an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including reporting protocols based on requirements under the *Health Protection and Promotion Act* and is complied with.

Sources: CIR, outbreak case file, document entitled Diseases of Public Health Significance from local health unit, licensee policy entitled Infection Surveillance, clinical record, interviews with IPAC lead, and other staff.

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