



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**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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Public Copy/Copie du public

Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 11, 2018	2018_624196_0016	019036-17, 023961-17, 003610-18	Complaint

Licensee/Titulaire de permis

CVH (No. 9) GP Inc. as general partner of CVH (No. 9) LP
766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Southbridge Roseview
99 Shuniah Street THUNDER BAY ON P7A 2Z2

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

LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): June 20 - 22, 2018.

This inspection was conducted to inspect a complaint related to medication administration and alleged resident to resident abuse; and two complaints related to resident care concerns.

During the course of the inspection, the inspector(s) spoke with the Executive Director/Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and Substitute Decision Makers (SDMs).

The Inspector conducted a walk through of resident care areas and observed the provision of care and services to residents. The Inspector also reviewed resident health care records, RN 24 Hour report documents, an internal medication incident report, and the registered nursing staff schedule.

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

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

1 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :



1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint was received by the Director which outlined concerns regarding a decline in the health status of resident #001, which resulted in acute care hospitalization for a specified period of time.

A review of the progress and electronic Medication Administration Record (eMAR) notes, for resident #001, over an approximate 48 hour time period, indicated the resident had a change in their health status.

A review of the RN 24 Hour report document did not reference resident #001 on any shifts on a specific date. The report noted that on the following date, the resident had an un-witnessed fall and a message had been left for the SDM.

The RN 24 Hour report document for another date could not be located by the Director of Care (DOC).

During an interview, RN #105 reported that if a resident's condition changed the SDM was to be notified, which would be documented in the progress notes.

During an interview, the Director of Care (DOC) reviewed the progress notes and the eMAR notes from a specific period of time of approximately 48 consecutive hours. The DOC reported that since this resident's decline in health status persisted, beyond an eight hour shift, the SDM should have been informed. The DOC confirmed there was no documentation in the residents' health care record to indicate the notification of the SDM until the note that indicated the family was present and wanted the resident sent to the hospital. [s. 6. (5)]



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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 that ensures that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker is given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

Issued on this 11th day of July, 2018

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

Original report signed by the inspector.