

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
May 7, 2021	2021_768693_0006	024642-20	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 9) 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 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

MELISSA HAMILTON (693), DEBBIE WARPULA (577), LAUREN TENHUNEN (196),
LISA MOORE (613)

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): This inspection was conducted on the following date(s): March 22 to 26, 2021, April 13 to 16, 2021, and April 19 to 21, 2021.

The following intake was inspected on during this Critical Incident System (CIS) inspection:

-one intake, regarding an allegation of staff to resident abuse.

Complaint (CO) inspection #2021_768693_0007, and Follow Up inspection #2021_768693_008 were conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with an Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and a resident.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, Infection Prevention and Control (IPAC) practices, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as relevant policies and procedures.

**The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation**

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

2 WN(s)

0 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>Légende</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. (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 care set out in the plan of care was provided to a resident as specified in the plan.

A Critical Incident System (CIS) report was submitted to the Director, regarding an allegation of abuse towards a resident by a PSW. The CIS report further identified that the PSW had entered the resident's room alone when the allegation of abuse occurred from resident #005.

A review of a resident's care plan indicated that two staff were required for care due to a responsive behaviour.

An ADOC confirmed that a PSW had not followed the resident's plan of care as they provided care without assistance from another staff member.

Sources: CIS report; the licensee's Zero Tolerance of Abuse and Neglect policy, dated June 2020; the home's investigation file; and an interview with an ADOC. [s. 6. (7)]

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker, if any and any other person specified by the resident was notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a resident.

A CIS report was submitted to the Director, regarding an allegation of abuse towards a resident by a PSW.

A review of progress notes identified that the resident's Substitute Decision Maker (SDM) was notified of the alleged abuse, a number of days after the incident had been reported.

An ADOC confirmed that the resident's SDM should have been notified within 12 hours, of the allegation of abuse.

Sources: CIS report; the licensee's Zero Tolerance of Abuse and Neglect policy, dated June 2020; and an interview with an ADOC. [s. 97. (1) (b)]

Issued on this 21st day of May, 2021

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

Original report signed by the inspector.