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_0007	020317-20, 024105-20, 024472-20, 024557-20, 024706-20, 024745-20, 024756-20, 024763-20, 025016-20, 025440-20, 026026-20, 026065-20, 000049-21, 002084-21, 003177-21	Complaint

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 Complaint inspection.

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 intakes were inspected upon during this Complaint inspection:

-one intake, regarding alleged resident to resident abuse, continence care, and nutrition concerns;
-one intake, regarding COVID-19 procedures;
-two intakes and a related CIS, regarding medication administration, hospital transfer, and housekeeping concerns;
-one intake, regarding staffing concerns;
-one intake, regarding Infection Prevention and Control (IPAC), staffing, and resident bathing concerns;
-one intake, regarding Registered Nurse (RN) requirements in the home;
-one intake, regarding staffing, medication administration, resident falls, and bathing concerns;
-two intakes, regarding IPAC concerns;
-one intake, regarding dietary, and plan of care concerns;
-one intake, regarding medication administration, and resident discharge concerns;
-two intakes, regarding restorative care, and skin and wound care concerns; and
-one intake, regarding alleged staff to resident verbal abuse, and responsive behaviours.

Critical Incident System (CIS) inspection #2021_768693_0006, and Follow Up inspection #2021_768693_008 were conducted concurrently with this Complaint inspection.

A finding of non-compliance related to s. 24. (1) 2. of the Long-Term Care Homes Act, 2007, identified in concurrent CIS inspection #2020_768693_0006, was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), previous Supporting DOC, previous Acting DOC, Assistant Directors of Care (ADOCs), Pharmacy Manager, Nurse Practitioners

(NPs), previous Program Manager, Program Manager, Food Services Manager (FSM), Manager of Environmental Health-Thunder Bay District Health Unit (TBDHU), the IPAC Specialist- North team Acting team Lead- Public Health Ontario, previous Volunteer Coordinator, Staff Development and Education Coordinator, Physiotherapist (PT), Registered Dietitian (RD), Registered Nurses (RNs), Public Health Nurse-TBDHU Registered Practical Nurses (RPNs), Resident Assessment Instrument (RAI) Coordinator, a Physiotherapist Assistant (PTA), Personal Support Workers (PSWs), Dietary Aides (DAs), the Residents Council President, residents, and their family members.

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:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
10 WN(s)
4 VPC(s)
3 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 O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident received end-of-life care in a manner that met their needs.

A resident was ordered a medication that was to be administered 'now'. Inspector #577 reviewed the resident's electronic medication administration record (eMAR), the Individual Monitored Medication Record, the Emergency box records and progress notes. There was no record of the order being processed or the medication being administered.

The next day the resident was ordered three additional medications for End-of-Life (EOL) care. Upon review of the resident's eMAR, the Individual Monitored Medication Record, the Emergency box records and progress notes, it was identified there was a delay in the administration of the medications.

During an interview with the NP, they indicated that the resident was uncomfortable, was considered EOL and they expected that the medications were to be given as ordered and not delayed or omitted.

Sources: complaint submitted to the Director; a residents's eMAR; emergency box records; Individual Monitored Medication Record for a resident; prescriber's orders for a resident; a resident's progress notes; "The Medication Pass, 3-6" policy (dated January 2018); and other policies, and interviews with the Nurse Practitioner and other relevant staff members. [s. 42.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure a resident was administered a drug that was prescribed for the resident.

Inspector #693 reviewed the home’s investigation notes for a medication incident. The investigation notes indicated that a resident, was given another residents medications. As a result, the resident was transferred to the hospital for monitoring, related to risk of medical complications.

Sources: a CIS report and a related complaint submitted to the Director; LTCH’s investigation file; interviews with the Supporting DOC, ADOCs, and other relevant staff members; interview with a resident's SDM; a residents progress notes; “The Medication Pass, 3-6" policy (dated January 2018); and an internal medication incident report. [s. 131. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when residents had fallen, the residents were assessed and that where the condition or circumstances of the residents required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

a) A review of progress notes for a resident, identified that the resident sustained a witnessed fall.

A review of the resident’s medical record identified a "Clinical Monitoring Record" that was initiated after the resident’s fall.The "Clinical Monitoring Record" indicated that staff were to complete vital signs, pain assessments, and monitor for cognitive changes after a witnessed fall, every eight hours, for 72 hours.

Together with Inspector #577, the DOC reviewed the "Clinical Monitoring Record" and indicated that the pain assessments and vital signs were not documented consistently, every eight hours, for 72 hours, on the record, after the resident’s fall.

b) A review of progress notes for another resident, identified that the resident sustained a number of falls, both witnessed and unwitnessed, during a time period.

Together with Inspector #577, the DOC reviewed the "Clinical Monitoring Record" and indicated that the pain assessments, vital signs, and neuro vital signs were not documented consistently every hour for four hours, and every eight hours for 72 hours on the record, after the residents falls; there wasn’t a "Clinical Monitoring Record" for one of the falls. Staff had not completed the required vital signs, neuro vital signs and pain assessments after the fall.

Sources: two complaints submitted to the Director; interviews with the DOC and other staff; resident’s progress notes, and care plans, Clinical Monitoring Records and post-fall assessments for residents; "Fall Prevention and Management Program. RC-15-01-01" (effective January 22, 2020). [s. 49. (2)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

In accordance with Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, dated September 9, 2020, “Staff who have tested positive and are symptomatic cannot attend work. In exceptional circumstances when a staff member has been deemed critical, the staff member who has tested positive and whose symptoms have resolved, or they remain asymptomatic may return to work under work self-isolation after a certain number of days.”

The home's internal investigation file identified that a staff member had tested positive for COVID-19 during surveillance testing. The result was received by the home via fax and the home's management and the Public Health Nurse from the TBDHU, had been unable to contact the staff member. It was further identified that the staff member had worked shifts, while they were positive for COVID-19.

In an interview, the then Acting DOC reported that when the home received the positive COVID-19 result, the staff member was removed from the schedule; their name was not on the schedule; the staff member didn't check their phone messages; and went on and worked their shifts.

In an interview, the ED indicated that Public Health would let the staff member know they were COVID-19 positive and the home was to ensure the staff member did not attend work.

Sources: complaint submitted to the Director; interviews with the then Acting DOC, an ADOC, TBDHU Public Health nurse and the ED; COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, dated September 9, 2020; after hours report and associated intake; PSW staff schedule; a resident's progress notes; and the LTCH's internal investigation file. [s. 5.]

2. In accordance with Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, dated September 9, 2020, the receiving home needed to have a plan that would ensure a resident being admitted (except for those who had cleared COVID-19) could complete 14-days of self-isolation, under droplet and contact Precautions.

A resident, who was required to self-isolate, was seated in the common TV lounge, wearing a surgical mask, positioned below their nose and another resident was seated less than 2 metres away.

In an interview, a PSW reported that the resident would not stay in their room and they were in the TV room that morning when the PSW came into work.

Sources: complaint submitted to the Director; observations of a resident; review of a resident's progress notes, care plan, and census record; review of Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, dated September 9, 2020; and interviews with PSW #122, the DOC, and other relevant staff members. [s. 5.]

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 the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with related to an incident of abuse involving residents.

An RN was informed of an allegation of abuse towards a resident by another resident.

The home’s abuse policy indicated that staff were to immediately report allegations of abuse to the Manager on call, as well, the registered staff were ensure the resident’s safety by providing support through completion of a full assessment or determining a plan to meet the resident’s needs

A review of a resident's progress notes, and the incident report prepared by an EN, identified that the RN did not document the incident in the progress notes, had not immediately notified the manager on call, and that they had not immediately responded to the alleged abuse by ensuring resident safety or providing support through completion of a full assessment or determining a plan to meet the resident’s needs.

Sources: complaint submitted to the Director; "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting,RC-02-01-02" (dated June 2020); resident's progress notes; internal Incident Report; and an interview with an ADOC. [s. 20. (1)]

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 without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident’s money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by another resident that resulted in a risk of harm, immediately reported the suspicion and the information upon which it is based to the Director.

An RN was informed of an allegation of abuse towards a resident by another resident. A review of the Long-Term Care Homes Portal did not indicate that the allegations of abuse had been reported to the Director.

Sources: complaint submitted to the Director; "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting,RC-02-01-02" (dated June 2020); Long-Term Care Homes Portal; and an interview with an ADOC . [s. 24.]

2. The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by a PSW that resulted in a risk of harm, immediately reported the suspicion and the information upon which it is based to the Director.

A CIS report was submitted to the Director, regarding an allegation of abuse towards a resident by a PSW. The CIS report identified that the incident was reported to the Director one day after it occurred.

Sources:a CIS report; "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting,RC-02-01-02" (dated June 2020) policy; and an interview with an ADOC. [s. 24. (1) 2.]

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 a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program as it related to wearing appropriate personal protective equipment.

An RPN was observed at the bedside of a resident. Signage on this resident's door identified contact and droplet precautions however, the RPN was noted to not wear a gown or gloves when at the resident's bedside.

CO #001 was issued during inspection #2020_829757_0031 pursuant to Ontario Regulation 79/10, s. 229. (4) with a compliance due date of March 31, 2021. As the compliance date was not yet due at the time of the observations made in this finding, the finding will be issued as a WN to further support the order.

Sources: observations; review of contact/droplet precautions signage; a resident's census records; interviews with an RPN and the DOC. [s. 229. (4)]

2. The licensee has failed to ensure that a hand hygiene program was in place in accordance with the Ontario evidence-based hand hygiene (HH) program, "Just Clean Your Hands (JCYH)" related to staff assisting residents with HH before and after meals.

In accordance with Public Health Ontario, Provincial Infectious Diseases Advisory Committee: Best Practices for Hand Hygiene in All Health Care Settings, 4th Edition, April 2014, hand hygiene in Long Term Care homes was to be provided to residents before and after meals.

Meal service was observed in three of the home areas, on three dates. HH was not provided to the residents before or after the meal service.

In interviews, a PSW and RPNs reported that there wasn’t a process for HH for residents before or after meals.

Sources: observations of residents during meal service; interviews with a PSW and RPNs; review of the home’s policies; "Meal Service and Dining Experience, NC-03-01-01" (dated December,2017), and "Hand Hygiene, IC-02-01-08" (dated October 2020); and “Public Health Ontario, Provincial Infectious Diseases Advisory Committee: Best Practices for Hand Hygiene in All Health Care Settings”, 4th Edition, April 2014. [s. 229. (9)]

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 there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents, to be implemented voluntarily.

WN #8: 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 there was a written plan of care for a resident that set out the planned care for the resident related to an intervention.

Inspector #613 observed an intervention, in use on the resident's room door frame. During an interview with a PSW, they stated the intervention was be in place and that this intervention was not in the resident’s care plan.

Sources: multiple observations of resident's room; review of a resident's care plan; and interviews with an ADOC, a PSW; and other relevant staff members. [s. 6. (1) (a)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to immediately forward written complaints that had been received concerning the care of a resident to the Director.

Inspector #577 reviewed an email received by the home's previous Volunteer Coordinator and previous Program Manager sent from a resident's family member. The email detailed various concerns related to the resident.

The home's complaints policy, indicated that the ED or designate would notify the Ministry of Long Term Care, via email, providing the written complaint and initial response letter; and would forward the final response letter to the complainant and Ministry of Long-Term Care, via email.

During an interview with the ED, they advised Inspector #577 that they had not forwarded the written complaint, initial response letter, or final response letter to the Ministry of Long Term Care (MLTC).

Sources: complaint submitted to the Director; a resident's progress notes; missing items form; email from a resident's family member; email from previous Program Manager; the home's Complaints and Customer Service policy (effective, May 9, 2019); interview with the RAI Coordinator, ED and other relevant staff members. [s. 22. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident was investigated and resolved where possible, and a response that complied with paragraph 3 provided within 10 business days of the receipt of the complaint.

See WN #9, finding #1, for further details.

The home’s complaints policy, indicated that the ED or designate would respond to all written concerns or complaints via email or mail, acknowledging the complaint, informing the complainant that an investigation had been initiated or conducted and assure them that a written response would be provided within 10 business days or sooner.

A review of an email sent from the previous Program Manager to the ED, detailed a phone conversation they had with a resident's family member that entailed a follow up to their concerns; the email had not included a response concerning an unwitnessed fall and the lack of assessment the following day.

During an interview with the ED, they advised that during the time period that the home was in a COVID-19 outbreak, the home had not followed the Complaints policy; had not responded to written concerns or complaints via email or mail, acknowledged the complaint, informed the complainant that an investigation had been initiated or conducted, or assured them that a written response would be provided within 10 business days or sooner.

Sources: complaint submitted to the Director; a resident's progress notes; email from a resident's family member; email from previous Program Manager, the home’s Complaints and Customer Service policy (effective, May 9, 2019); interview with the ED and other relevant staff members. [s. 101. (1) 1.]

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.

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : MELISSA HAMILTON (693), DEBBIE WARPULA (577), LAUREN TENHUNEN (196), LISA MOORE (613)

Inspection No. / No de l'inspection : 2021_768693_0007

Log No. / No de registre : 020317-20, 024105-20, 024472-20, 024557-20, 024706-20, 024745-20, 024756-20, 024763-20, 025016-20, 025440-20, 026026-20, 026065-20, 000049-21, 002084-21, 003177-21

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : May 7, 2021

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

LTC Home / Foyer de SLD : Southbridge Roseview
99 Shuniah Street, Thunder Bay, ON, P7A-2Z2

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Joanne Lent

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To 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.), you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Order / Ordre :

The licensee must be compliant with s. 42 of the Ontario Regulation 79/10.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident received end-of-life care in a manner that met their needs.

A resident was ordered a medication that was to be administered 'now'. Inspector #577 reviewed the resident's electronic medication administration record (eMAR), the Individual Monitored Medication Record, the Emergency box records and progress notes. There was no record of the order being processed or the medication being administered.

The next day the resident was ordered three additional medications for End-of-Life (EOL) care. Upon review of the resident's eMAR, the Individual Monitored Medication Record, the Emergency box records and progress notes, it was identified there was a delay in the administration of the medications.

During an interview with the NP, they indicated that the resident was uncomfortable, was considered EOL and they expected that the medications were to be given as ordered and not delayed or omitted.

Sources: complaint submitted to the Director; a residents's eMAR; emergency box records; Individual Monitored Medication Record for a resident; prescriber's orders for a resident; a resident's progress notes; “The Medication Pass, 3-6" policy (dated January 2018); and other policies, and interviews with the Nurse Practitioner and other relevant staff members. [s. 42.]

An order was made by taking the following factors into account:

Severity: There was actual harm. A resident was uncomfortable, and did not receive the prescribed end-of-life measures, when they were palliative.

Scope: The scope of this non-compliance was isolated, as only one resident was affected.

Compliance History: The licensee was found to be non-compliant with different sections of the legislation in the last 36 months.
(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 08, 2021

Order # / No d'ordre : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Order / Ordre :

The licensee must be compliant with s. 131. (1) of the Ontario Regulation 79/10.

Specifically, the licensee must:

- provide training to non-regular registered staff on the home's policies for medication administration; specifically related to the use of appropriate identifiers to ensure the correct resident is administered medications as prescribed;

- ensure the training is completed by non-regular registered staff before they are responsible for administering medications; and

- maintain a record of the training, what the training entailed, who completed the training and when the training was completed.

Grounds / Motifs :

1. The licensee has failed to ensure a resident was administered a drug that was prescribed for the resident.

Inspector #693 reviewed the home's investigation notes for a medication incident. The investigation notes indicated that a resident, was given another residents medications. As a result, the resident was transferred to the hospital for monitoring, related to risk of medical complications.

Sources: a CIS report and a related complaint submitted to the Director; LTCH's investigation file; interviews with the Supporting DOC, ADOCs, and other relevant staff members; interview with a resident's SDM; a residents progress notes; "The Medication Pass, 3-6" policy (dated January 2018); and an internal medication incident report. [s. 131. (1)]

An order was made by taking the following factors into account:

Severity: There was actual risk. A resident was given another resident's medications, and as a result transferred to the hospital, for monitoring, related to risk of medical complications.

Scope: The scope of this non-compliance was isolated, as only one resident was affected, out of the three residents that were reviewed during this inspection.

Compliance History: The licensee was found to be non-compliant with different sections of the legislation in the last 36 months. (693)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 08, 2021

Order # / No d'ordre : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee must be compliant with s. 49. (2) of the Ontario Regulation 79/10.

Specifically the licensee must:

- ensure that the "Clinical Monitoring Record" is completed as required, after each fall sustained by a resident;

- retrain Registered staff on the home's policy, "Fall Prevention and Management Program, RC-15-01-01", ensuring that training related to the "Clinical Monitoring Record" is included; and

- maintain a record of the retraining, what the training entailed, who completed the training and when the training was completed.

Grounds / Motifs :

1. The licensee has failed to ensure that when residents had fallen, the residents were assessed and that where the condition or circumstances of the residents required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

a) A review of progress notes for a resident, identified that the resident sustained a witnessed fall.

A review of the resident's medical record identified a "Clinical Monitoring Record" that was initiated after the resident's fall.The "Clinical Monitoring

Record" indicated that staff were to complete vital signs, pain assessments, and monitor for cognitive changes after a witnessed fall, every eight hours, for 72 hours.

Together with Inspector #577, the DOC reviewed the "Clinical Monitoring Record" and indicated that the pain assessments and vital signs were not documented consistently, every eight hours, for 72 hours, on the record, after the resident's fall.

b) A review of progress notes for another resident, identified that the resident sustained a number of falls, both witnessed and unwitnessed, during a time period.

Together with Inspector #577, the DOC reviewed the "Clinical Monitoring Record" and indicated that the pain assessments, vital signs, and neuro vital signs were not documented consistently every hour for four hours, and every eight hours for 72 hours on the record, after the residents falls; there wasn't a "Clinical Monitoring Record" for one of the falls. Staff had not completed the required vital signs, neuro vital signs and pain assessments after the fall.

Sources: two complaints submitted to the Director; interviews with the DOC and other staff; resident's progress notes, and care plans, Clinical Monitoring Records and post-fall assessments for residents; "Fall Prevention and Management Program. RC-15-01-01" (effective January 22, 2020). [s. 49. (2)]

An order was made by taking the following factors into account:

Severity: There was actual risk. The residents had sustained multiple falls, and the "Clinical Monitoring Record"was not consistently completed after each fall, which indicated the residents were not monitored for pain, vital signs, neurological vital signs, or cognitive changes; as per the home's falls program, after each fall.

Scope: The scope of this non-compliance was a pattern because a "Clinical Monitoring Record", after each fall, was not completed for two of the three residents reviewed during this inspection.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg. 79/10, s. 49. (2) and one Voluntary Plan of Correction (VPC) was issued to the home. (693)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 08, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 7th day of May, 2021

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Melissa Hamilton

Service Area Office / Bureau régional de services : Sudbury Service Area Office