Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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
Dec 1, 2021	2021_829757_0025	013235-21, 014997-21, 015083-21, 015362-21, 016097-21, 016966-21, 017109-21, 017290-21, 017806-21, 017877-21	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

DAVID SCHAEFER (757), MELISSA HAMILTON (693)

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): November 1-5 & 8-10, 2021.

The following intakes were inspected during this Complaint inspection:
-Eight intakes related to concerns regarding resident care, sufficient staffing, infection prevention and control (IPAC), housekeeping, recreation, and abuse.
-Two intakes related to concerns regarding IPAC and sufficient staffing.

This inspection was conducted concurrently with Critical Incident System (CIS) inspection #2021_829757_0024.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant DOCs (ADOCs), Environmental Services Manager (ESM), Food Services Manager (FSM), Behavioural Supports Lead, Northwest Regional IPAC Specialist, Physiotherapist (PT), Recreational Therapists (RTs), staff educator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), dietary aides, housekeepers, and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, staff-to-resident interactions, resident-to-resident interactions, and reviewed relevant resident health care records, internal investigation files, as well as specific licensee policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 VPC(s)**
- **0 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policies and procedures included in the required falls prevention and management; and dietary services and hydration programs were complied with for a resident.

A) Ontario Regulation (O. Reg.) 79/10, s. 48 (1) required the home to develop and implement a falls prevention and management program to reduce the incidence of falls and the risk of injury.

Specifically, staff did not comply with the home's policy "Falls Prevention and Management Program", dated December 2020. A resident had multiple unwitnessed falls.

The policy indicated that when a resident fell and hit their head, or was suspected of hitting their head, such as in the event of an unwitnessed fall, that a clinical monitoring record including vital signs, pain assessment, and neurological vital signs, was required to be completed for the resident. After each of the resident's falls, the clinical monitoring record was not completed in full with respect to monitoring the resident for vitals signs, pain, and neurological vital signs. ADOC #102 indicated that the clinical monitoring record was required to be completed in full following each of the resident's falls. The failure to complete the clinical monitoring record increased the risk of delayed discovery of a worsening head injury.

B) The Long-Term Care Homes Act (LTCHA), s. 11 (1) (b) required an organized program of dietary services to meet the dietary needs of residents.

Specifically, staff did not comply with the home's policy "Diet Orders", last updated

December 2020.

An order was made by a Speech-Language Pathologist (SLP) to change a resident's required fluid thickness. Five days following the order, the resident's care plan and dietary reference list had not been updated to reflect the change. The Food Services Manager (FSM) indicated that it was their responsibility to ensure a resident's dietary reference list was updated following a change in diet orders, and that this should have occurred on the day the order was made. ADOC #102 indicated that updating the care plan related to fluid thickness was the responsibility of the nursing staff. The failure to promptly update the resident's plan of care related to fluid thickness increased the resident's risk of choking and aspiration.

Sources: A resident's care plan, progress notes, post-fall assessments, and clinical monitoring records; observation of a resident's dietary reference list; the home's policy "Falls Prevention and Management Program (RC-15-01-01)", dated December 2020; the home's policy "Diet Orders (RC-18-01-02)", dated December 2020; interviews with the FSM, ADOC #102, and other relevant staff members. [s. 8. (1) (b)]

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 policies and procedures included in the required falls prevention and management and dietary services and hydration programs are complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was dressed appropriately and in keeping with their preference.

A resident was left in clothing that was inappropriate. The resident's power of attorney for personal care (POA) indicated that the resident considered being dressed as they were on this day to be indecent. The home was informed by the POA that this was not appropriate dress for the resident, specified the resident's preference for clothing, and brought additional appropriate clothing to the home. Less than a week following the initial incident, the resident was again found to have been left in inappropriate clothing. ADOC #102 indicated that this was not an appropriate manner to dress the resident, and that staff should have attempted to obtain appropriate clothing from the laundry department; or if no clothing in keeping with the resident's preference was available, called the POA to determine if other appropriate clothing would be acceptable in the circumstance.

Sources: A resident's care plans and progress notes, the home's internal investigation notes; and interviews with ADOC #102, and other relevant staff members. [s. 40.]

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 resident is dressed appropriately and in keeping with their preferences, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident exhibited altered skin integrity, they were reassessed at least weekly by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A resident was noted to have an area of altered skin integrity. An assessment was completed using the electronic "Weekly Impaired Skin Integrity Assessment" tool.

The home's policy "Skin and wound program: wound care management (RC-23-01-02)" indicated that this assessment tool was required to be used to assess altered skin integrity upon initial discovery and then at a minimum of every seven days. The assessment tool was not completed again until almost two weeks after the initial assessment, at which time the area of altered skin integrity had worsened. ADOC #102 indicated that the "Weekly Impaired Skin Integrity Assessment" should have been completed again within seven days following the initial assessment.

Sources: A resident's progress notes and electronic weekly impaired skin integrity assessments; policy "Skin and wound program: wound care management (RC-23-01-02)", dated December 2020; interviews with ADOC #102 and other relevant staff members. [s. 50. (2) (b) (iv)]

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 where residents exhibit altered skin integrity, they are reassessed at least weekly by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was monitored during a meal.

A resident was observed to be alone in their room with their breakfast plate. The resident had vomited on their plate and the resident's face was on the plate. The resident was required to receive supervision while eating. An RN indicated that the resident was at risk for aspiration as a result of the incident. ADOC #102 indicated that the resident should not have been left alone with their breakfast plate and that they were not properly monitored during the meal service.

Sources: A resident's care plan; observation of a resident; interviews with an RN and ADOC #102. [s. 73. (1) 4.]

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 all residents are monitored during meals, to be implemented voluntarily.

WN #5: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care set out in a resident's plan of care was documented, with respect to hourly safety checks.

Hourly safety checks were implemented in a resident's plan of care, and care staff were required to document the provision of these checks in their electronic Point of Care (POC) documentation. The POC documentation related to these safety checks was not completed throughout a shift. ADOC #102 indicated that the provision of this intervention should have been fully documented.

Sources: A resident's progress notes and POC documentation; the home's internal investigation notes; and an interview with ADOC #102. [s. 6. (9) 1.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was kept clean and sanitary, with respect to a resident's room.

During the admission for a resident, their room and bathroom had not been properly cleaned, stocked, or prepared.

The home's housekeeping policies indicated that resident rooms and bathrooms were required to be cleaned daily including disinfecting and washing of the toilet, and replenishing of bathroom supplies. The policies also indicated that prior to a resident moving in to a new room, a final inspection of the room was to be conducted to ensure that it was clean, tidy, and ready for the resident.

The Environmental Services Manager (ESM) acknowledged they were unable to conduct a final inspection that day prior to admission and that the room had not been cleaned to the required standard. They indicated that the resident experienced a poor admission as a result of improper housekeeping.

On another day, food debris was found to have been left on the resident's floor after housekeeping staff had left for the day. ADOC #102 indicated it was the responsibility of the PSW or nursing staff to clean up spills including food debris, and that this debris should have been cleaned by the staff member who had fed the resident.

Sources: A resident's care plan; the home's policy "Cleaning Frequency (HL-05-01-09)", dated February 2021, policy "Resident Room/Washroom Cleaning (HL-05-01-10)", dated February 2021; policy "Resident Room Cleaning on Discharge/Room Change (HL-05-01-11), dated February 2021; interviews with the ESM, ADOC #102, and a housekeeper. [s. 15. (2) (a)]

Issued on this 3rd day of December, 2021

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

Original report signed by the inspector.