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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: January 25, 2024

Inspection Number: 2023-1351-0006

Inspection Type:
Complaint
Critical Incident

Licensee: CVH (No. 9) 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: Southbridge Roseview, Thunder Bay

Lead Inspector	**Inspector Digital Signature**
Christopher Amonson (721027)	Christopher E Amonson Digitally signed by Christopher E Amonson Date: 2024.01.30 13:02:11 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 20 - 24, 2023

The following intake(s) were inspected:

- One intake related to responsive behaviours;
- One intake related to a fall of resident resulting in injury; and
- One intake related to alleged physical abuse of a resident.

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

Infection Prevention and Control
Responsive Behaviours

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Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee failed to ensure that a resident was protected from abuse by staff.

Rationale and Summary

There was an altercation between a staff member and a resident, where the staff was witnessed reacting to a resident in an unprofessional manner.

The Director of Care (DOC) indicated that the staff member involved in the altercation had not utilized the appropriate interventions for the resident, which had escalated the altercation.

Sources: Resident health records; Long-term Care (LTC) home's investigation file; LTC home's policy titled "Responsive Behaviours: RC-17-01-04", last reviewed March 2023; interviews with DOC and staff. [721027]

WRITTEN NOTIFICATION: Reporting Certain Matters to the

Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (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:

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.

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

Rationale and Summary

There were altercations between residents that resulted in an injury to one of the residents.

The incidents between the residents were witnessed and documented by staff. Registered staff indicated that any occurrence of suspected abuse should be immediately reported to the Director. The DOC acknowledged that no critical incident report was submitted to the Director for the incidents.

Sources: Residents health records; LTC Homes Portal; LTC Home's policy titled "Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct: RC-02-01-01 (reviewed August 2023); interviews with DOC and staff. [721027]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Skin and wound care

s. 55 (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,

The licensee failed to ensure that a resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff.

Rationale and Summary

A resident was noted to have had injuries after altercations with another resident; however, no assessments were completed and documented by registered staff.

Both the DOC and registered staff indicated that assessments were to be completed after an altercation between residents, or when a resident was observed having altered skin integrity. Upon review of the home's electric and physical charting for the residents, the DOC confirmed there were no assessments documented for the altercations that occurred.

Sources: Residents health records; LTC home policy titled Responsive Behaviours: RC-17-01-04, (last reviewed March 2023); and interviews with the DOC and staff. [721027]

WRITTEN NOTIFICATION: Altercations Between Residents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 59 (b)

Altercations and other interactions between residents
s. 59 (b) identifying and implementing interventions.

The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful actions between residents, including, identifying and implementing interventions.

Rationale and Summary

There were altercations between two residents, which resulted in one of the residents sustaining minor injuries.

The DOC confirmed that interventions were not identified and implemented between the altercations, despite staff indicating that a resident remained agitated after an altercation.

Sources: Residents health records; LTC home policy titled Responsive Behaviours: RC-17-01-04, (last reviewed March 2023); interviews with DOC and staff. [721027]