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
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Original Public Report

Report Issue Date: September 10, 2024
Inspection Number: 2024-1351-0002
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**
Eva Namysl (000696)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 19 - 22, 2024.

The following intake(s) were inspected:

- A complaint related to a safe and secure home and a missing resident.
- An intake related to a missing resident less than 3 hours.
- A complaint related to alleged abuse of a resident.
- An intake related to a medication incident/adverse drug reaction of a resident.
- A complaint regarding a medication incident of a resident.

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

Skin and Wound Prevention and Management

Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Skin and wound care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
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 injuries, skin tears or wounds,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee has failed to ensure that a resident who was exhibiting altered skin integrity, received immediate treatment and interventions to reduce pain, promote healing, and prevent infection, as required.

Rationale and Summary
A complaint was submitted to the Director concerning new altered skin integrity on a resident that was from an unknown cause.

A review of the resident's health record identified that interventions were not put in

place to promote healing.

The Director of Care (DOC) confirmed procedures were not followed in reference to resident's altered skin integrity.

Failure to ensure the resident received immediate interventions presented a risk for further skin breakdown and prolonged pain or discomfort.

Sources: Review of resident's health records and assessments; Interview with DOC; And review of complaint submitted to the Director.

WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
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 injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure a resident who was exhibiting altered skin integrity, was reassessed at least weekly by an authorized person.

Rationale and Summary
Progress notes for a resident revealed they had new altered skin integrity.

No documented weekly skin assessments occurred after an initial skin integrity assessment that was completed for the resident.

A Registered Practical Nurse (RPN) reported that weekly skin assessments should occur, when clinically indicated, until skin impairment has resolved.

Not having weekly skin assessments put the resident at risk for further skin breakdown.

Sources: Review of a resident's health records and assessments; And interviews with two staff members.

WRITTEN NOTIFICATION: Dealing with complaints

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.
Dealing with complaints
s. 108 (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 including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

The licensee failed to ensure that a verbal complaint made to the DOC concerning care of a resident was investigated and resolved where possible.

Rationale and Summary
A verbal complaint was brought forward regarding a resident's care to the DOC. Following this interaction, the DOC did not document the nature of the complaint and did not take any action to investigate or resolve the complaint.

An interview with the DOC confirmed that the verbal complaint had not been investigated or actioned.

Sources: Review of a resident's health records; Interviews with complainant and DOC.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 1.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

The licensee failed to ensure that the Director was informed, of a resident who was missing for less than three hours, no later than one business day after the occurrence of the incident, followed by the report required under subsection (5).

Rationale and Summary
On a particular date, a resident was returned to the home after being located outside of the property.

The Associate Director of Care (ADOC) confirmed they did not submit a critical incident report to the Director for this incident.

Sources: A resident's progress notes; Review of the home's internal investigation; And interview with the ADOC.

WRITTEN NOTIFICATION: Administration of drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)
Administration of drugs
s. 140 (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. 246/22, s. 140 (1).

The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Rationale and Summary
A Critical Incident (CI) report, identified that a resident received the wrong medications which resulted in an adverse reaction.

Through home's internal investigation it was determined that the resident had received the medication in error.

In an interview with the DOC, they indicated that a RPN had administered medication to the resident in error.

The home's failure to ensure that the resident received the right medications had a moderate impact to the resident.

Sources: Resident's health records; Complaint and Critical Incident report; Home's investigation documents; And interviews with the DOC and SDM.