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

Public Report

Report Issue Date: January 28, 2025

Inspection Number: 2025-1351-0001

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 20 - 24, 27, 2025

The following intake(s) were inspected:

- One intake related to an infectious disease outbreak;
- One intake related to a complaint re: injury of a resident;
- One intake related to a complaint re: resident care; and
- One intake related to a complaint re: maintenance services.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Housekeeping, Laundry and Maintenance Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to ensure that staff and others involved in providing care for a resident, collaborated with each other; resulting in certain aspects of care not being implemented.

Sources: Complaints submitted to the director; a resident's health records; the home's policy titled "Preventative Skin Care", reviewed August 2024; supply order documentation; interviews with the Nurse Practitioner and Director of Care (DOC).

WRITTEN NOTIFICATION: Involvement of power of attorney

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and

implementation of the resident's plan of care.

The licensee failed to ensure that a resident's Power of Attorney (POA) was given the opportunity to participate in the implementation of the resident's plan of care.

Sources: Complaints submitted to the director, a resident's health records; the home's policy titled "Preventative Skin Care", reviewed August 2024; supply order documentation; interviews with the Nurse Practitioner and DOC.

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;

The licensee has failed to ensure the home, furnishings and equipment were kept clean and sanitary.

During on-site inspection observations, the overall cleanliness of the facility was found to be poor. Specifically noted, but not limited to, were the following concerns:

Stains on nursing station desks
Dirty kitchen floors and ceiling tiles
Stains on the walls of some resident rooms

Sources: Complaints submitted to the Director; Inspector observations.

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, 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.

The licensee failed to ensure that staff complied with the long-term care home's (LTCH) policy to promote zero tolerance, when an incident that was witnessed by staff was not immediately reported to the LTCH and Director.

Sources: Complaints submitted to the director; a resident's health records; the home's policy titled "Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct", reviewed August 2024; interviews with staff and DOC.

WRITTEN NOTIFICATION: Air temperature

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee failed to ensure that the home consistently maintained temperatures at a minimum of 22 degrees Celsius.

Sources: Inspector observations; LTCH Air Temperature and Humidity Logs;

interviews with staff and Environmental Services Manager (ESM).

WRITTEN NOTIFICATION: Reports re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
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):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that the Director was informed of an incident that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

Sources: Interview with the Director of Care (DOC); review of a resident's health records.

WRITTEN NOTIFICATION: Administration of drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The Licensee failed to ensure that a drug was administered to a resident in accordance with directions for use as specified by the prescriber.

Sources: Complaints submitted to the director; a resident's health records; LTCH medication incident report; and interviews with staff, Nurse Practitioner and Director of Care DOC.

COMPLIANCE ORDER CO #001 Specific duties re cleanliness and repair

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Develop a written plan of correction outlining the steps that will be taken to address the outstanding maintenance and housekeeping concerns identified in the home. The written plan must include details of:
a) anticipated dates or schedule for completion;
b) who is responsible for completing each component of the written plan;
c) what monitoring process will be put in place to ensure oversight of the plan's implementation.

Grounds

The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Rationale and Summary
During an on-site inspection, the inspector observed several areas of the home requiring repair and attention. Specifically noted, but not limited to, were the following concerns:

Broken floor tiles in a main hallway and resident common areas
Shower in need of repair
Spa room flooring and entryways to showers requiring repair
Cracked glass window
Stained or missing ceiling tiles in kitchen and public areas
Missing lightbulbs/lighting in common areas
A pile of broken equipment outside the building
Worn out furniture in resident common areas

The observed deficiencies of the home posed risks to the safety and well-being of residents.

Sources: Inspector observations; Interview with the Environmental Service Manager; And review of complaints submitted to the Director.

This order must be complied with by February 14, 2025

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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