Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

Original Public Report

Report Issue Date August 26, 2022
Inspection Number 2022_1037_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Southbridge Health Care GP Inc. and Southbridge Care Homes

Long-Term Care Home and City
Seaforth Long Term Care Home, Seaforth

Lead Inspector
Debbie Warpula (577)

Inspector Digital Signature
Debbie L Warpula
Digitally signed by Debbie L Warpula
Date: 2022.09.01 09:12:13 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 18 – 21, 25 – 29, 2022
The following intake(s) were inspected:

- Intake #007033-22 related to a resident fall with injury.
- Intake #007082-22 related to care concerns and a resident fall with injury.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Reporting and Complaints
- Safe and Secure Home

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

WRITTEN NOTIFICATION [INFECTION PREVENTION AND CONTROL]

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

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Non-compliance with: O. Reg. 246/22 s. 102 (8)

The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control (IPAC) program.

Rationale and Summary:

A)The IPAC Standard for Long-Term Care Homes dated April 2022, states the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program.

Review of the homes specific policy indicated additional precautions were required for an identified highly contagious infection. Room signage was required for any residents requiring additional precautions related to the identified infection. Three negative testing results were required for any resident with the infection as directed by the home's policy before the additional precautions were discontinued.

During a record review of the home's specified precaution list, Inspector #577 noted that a resident was on specific precautions for a specified medical condition.

On an identified date, Inspector #577 observed a Personal Support Worker (PSW) and a resident's Essential Caregiver (EC) in the resident's room, not wearing PPE. Inspector asked the PSW whether the resident was on specific precautions and directed the PSW to the specific precautions sign on the door. The PSW stated that they didn't know and did not wear PPE in the resident's room. The EC informed Inspector #577 that they have never been informed that the resident was on specific precautions, had never worn PPE and stated staff had never worn PPE when in the room and providing care.

On another identified date, Inspector #577 noted that the specific precautions sign was removed from the resident's doorway. During an interview with the IPAC Lead and the Regional IPAC Specialist, they indicated that the Director of Care (DOC) had misinterpreted one of the home's specific policies, discontinued the specific precautions for 24 hours (hrs), when the specific precautions should not have been discontinued.

During an interview with a PSW on an identified date, they advised that during the morning huddle, the IPAC Lead advised staff to wear specific PPE for the resident and indicated that previous to that staff had not been donning PPE and had never been directed to.

On an identified date, Inspector #577 observed a resident's EC in the resident's room not wearing any PPE. Inspector noted during observations, the family member was sitting on the resident's bed, touching the resident and feeding them a snack. They said that the home had advised them that they didn't need to donn PPE as they were not providing care.

During an interview with Huron-Perth Public Health, they advised that any visitors/family member for the resident should be donning specific PPE as they were in the resident's room, exposed to the resident's environment, sitting on their bed and touching their personal items.

During an interview with the DOC, they indicated that they had removed the specific precautions sign the day before for the resident as they thought this was appropriate. Inspector #577 directed the DOC to the home's policy for specified medical conditions, which indicated that specific precautions would be discontinued after a specific number of tests taken over a specific time period apart had been received.

During an interview with the Executive Director (ED) they advised that the resident's EC was required to wear specific PPE. Inspector #577 advised the ED of Huron-Perth Public Health's recommendations.

The home not following specific precautions, appropriate PPE and PH Guidelines for staff and a visitor impacted the home's IPAC Program, as evidenced by IPAC non-compliance in the home.

Sources: Observations of IPAC practices in the home, interviews with PSWs, an EC, ED, DOC, IPAC Lead and Regional IPAC Specialist, Huron-Perth Public Health, review of a resident's medical records, review of the IPAC Standard for Long-Term Care Homes dated April 2022, the home's policy "Methicillin-Resistant Staphylococcus Aureus (MRSA) Infection – IC-05-01-03" reviewed January 2022, the home's ARO Tracking Sheet', the home's policy "Colonized ARO's – IC-05-01-12" reviewed April 2022, Huron-Perth Public Health's document "Screening, Testing and Surveillance for AROs in all Health Care Settings" and the Minister's Directive: COVID-19 response measures for long-term care homes effective April 27, 2022.

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B) During a record review of the home's specified precaution list, Inspector #577 determined that the home had a specific number of residents on specific precautions for specified medical conditions. Inspector confirmed this with the IPAC Lead.

Review of the homes specific policy indicated that three negative testing results were required for any resident with the infection as directed by the home's policy before the additional precautions were discontinued.

Review of one of the home's specific policies indicated that all positive results were to be retested in three months and all negative results were to be retested one week apart for three weeks.

A review of the home's specified precautions tracking sheet revealed inconsistencies for testing frequencies for four residents.

During an interview with a Registered Nurse (RN) they advised that RNs were responsible to collect swabs for specified medical conditions; they follow the specified tracking sheet and indicated that the swabs had not been collected according to the testing schedule. They further advised that the IPAC Lead was responsible for monitoring the tracking of swabs and it had not been done.

During an interview with the IPAC Lead and Regional IPAC Specialist they reported that a calendar had been in place to track when swabs were due, and it had not been used correctly. The RN would be responsible for swabs being done. The IPAC Lead spoke with an RN who advised that swabs weren't done and they did not remember when they were last collected for resident's with specified medical conditions.

During an interview with the ED, together with Inspector #577, reviewed the specified tracking sheet. They confirmed the inconsistencies and advised that the IPAC Lead was responsible for tracking, and an RN was the Co-Lead for IPAC and together with the Quality Manager, were responsible for the tracking of specified medical conditions.

Sources: Observations of IPAC practices in the home, interviews with an RN, IPAC Lead and Regional IPAC Specialist, Huron-Perth Public Health, review of four resident's medical records, review of the IPAC Standard for Long-Term Care Homes dated April 2022, the home's policy "Methicillin-Resistant Staphylococcus Aureus (MRSA) Infection – IC-05-01-03" reviewed January 2022 and "Extended Spectrum Beta Lactamase (ESBL) Infection – IC-05-01-04" reviewed April 2022, the home's specified tracking sheet, the home's policy "Colonized ARO's – IC-05-01-12" reviewed April 2022, Huron-Perth Public Health's document "Screening, Testing and Surveillance for AROs in all Health Care Settings" and the Minister's Directive: COVID-19 response measures for long-term care homes effective April 27, 2022.

WRITTEN NOTIFICATION [FALLS PREVENTION AND MANAGEMENT]

NC#002 Written Notification pursuant to LTCHA, 2007, O. Reg. 79/10

Non-compliance with: O. Reg. 79/10 s. 48 (1) 1

The licensee has failed to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home. Specifically, the home did not implement the " Neurological Signs/Head Injury Routine" required for a resident.

Summary and Rationale:

A CIS report was submitted to the Director on an identified date, concerning a resident who had a fall, suffered a specific injury and required medical care at a hospital.

An anonymous complaint was received by the Director on a specified date, related to care concerns and a resident's fall with injuries.

Review of the home's Falls Prevention and Management Program indicated that as part of their post fall, staff were required to complete specific assessments and monitoring. The home did not follow their policy related to post-fall assessments.

Review of one of the home's specific policies indicated that the nurse would implement a specific routine and monitoring whenever a resident had a specified injury.

A resident's specific monitoring record was initiated on an identified date and the resident was transferred to a hospital. The progress notes indicated that they returned from the hospital the following day at a specified time. Specific monitoring was re-initiated a day later at a specified time, and all the components of the monitoring were not completed as required, including specific assessments.

During an interview with the ED, together with Inspector #577, reviewed the resident's specific monitoring record. They confirmed that staff did not complete the specified monitoring as required.

The home not completing the resident's specified monitoring put the resident at risk as they failed to assess the resident as required.

Sources: review of a CIS report and complaint, review of the resident's progress notes and specified monitoring recod, review of the home's "Neurological Signs/Head Injury Routine – RC-25-01-38" reviewed January 2022, review of the home's "Falls Prevention and Management Program – RC-15-01-01" reviewed January 2022 and an interview with the ED.

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WRITTEN NOTIFICATION [FORWARDING COMPLAINTS]

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

Non-compliance with: FLTCA, 2021 s. 26 (1) c
The licensee has failed to ensure that a written complaint concerning the care of a resident or operations of the home was immediately forwarded to the Director.

Rationale and Summary:
An anonymous complaint was received by the Director on an identified date, related to a resident's fall with injuries and care concerns.

The complainant provided Inspector #577 with copies of two emails forwarded to the home, which entailed many care concerns. The email on an identified date, was forwarded to the ED and DOC.

Review of home's policy "Complaints and Customer Service – RC-09-01-04" reviewed April 2022, indicated that the home would communicate confirmation to the complainant that the

home immediately forwarded the complaint to the Ministry in instances where a written complaint alleges harm or risk of harm.

During an interview with the ED, they advised that any written complaints they had received were not submitted to the Director, as they would ask the complainant if they wanted it forwarded to the Ministry or resolved internally.

Sources: Review of two email threads forwarded from the complainant to the DOC and ED, review of home's policy "Complaints and Customer Service – RC-09-01-04" reviewed April 2022, interviews with the complainant, an RN and the ED.

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WRITTEN NOTIFICATION [FORWARDING COMPLAINTS]

NC#004 Written Notification pursuant to LTCHA, 2007

Non-compliance with: LTCHA, 2007 s. 22 (1)
The licensee has failed to ensure that a written complaint concerning the care of a resident or operations of the home was immediately forwarded to the Director.

Rationale and Summary:
An anonymous complaint was received by the Director on an identified date, related to a resident's fall with injuries and care concerns.

The complainant provided Inspector #577 with copies of two emails forwarded to the home, which entailed many care concerns. An email on an identified date, was forwarded to the ED and DOC.

Review of home's policy "Complaints and Customer Service – RC-09-01-04" reviewed April 2022, indicated that the home would communicate confirmation to the complainant that the home immediately forwarded the complaint to the Ministry in instances where a written complaint alleges harm or risk of harm.

During an interview with the ED, they advised that any written complaints they had received were not submitted to the Director, as they would ask the complainant if they wanted it forwarded to the Ministry or resolved internally.

Sources: Review of two email threads forwarded from the complainant to the DOC and ED, review of home's policy "Complaints and Customer Service – RC-09-01-04" reviewed April 2022, interviews with the complainant, an RN and the ED.

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WRITTEN NOTIFICATION [REPORTING AND COMPLAINTS]

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 108 (1) 1

The licensee has failed to ensure that a response was provided within 10 business days of the receipt of the complaint concerning a written complaint made to the DOC and ED concerning the care of a resident, and where the complaint alleged harm or risk of harm to the resident, the investigation was commenced immediately.

Rationale and Summary:

Complainant provided Inspector #577 with copies of two emails forwarded to the home, which contained many care concerns. The email on an identified date, was forwarded to the ED and DOC and contained concerns related to unsafe care, lack of privacy provided to the resident and the hygiene and cleanliness of the residents room.

Review of home's policy "Complaints and Customer Service – RC-09-01-04" reviewed April 2022, indicated that the home would ensure that families/SDMs received a response within the required legislative time frames and the addressed concerns were documented. The home would initiate an investigation into the circumstances leading to the complaint within 24 hours and complete the investigation within ten days; they would provide a written response at the conclusion of the investigation. The written response would include what the home had done to resolve the complaint and the reasons why this conclusion was reached if the complaint was unfounded. And confirmation that the home immediately forwarded the complaint to the Ministry in instances where a written complaint alleges harm or risk of harm, including but not limited to physical harm to one or more residents. They would provide follow up to acknowledge the complaint, inform complainant that an investigation had been initiated/conducted and assure the complainant that a written response would be provided within ten days or sooner.

During an interview with the complainant, they advised that when they forwarded an email on an identified date, there wasn't a follow up meeting or response given.

During an interview with the ED, they were unable to provide any documentation related to the complaint received on an identified date.

The home failed to investigate a written complaint concerning unsafe care, putting the resident at risk of further harm.

Sources: Review of two email threads forwarded from the complainant to the DOC and ED, review of home's policy "Complaints and Customer Service – RC-09-01-04" reviewed April 2022, interviews with the complainant, an RN and the ED.

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WRITTEN NOTIFICATION [REPORTING AND COMPLAINTS]

NC#006 Written Notification pursuant to LTCHA, 2007 O. Reg. 79/10

Non-compliance with: O. Reg. 79/10 s. 101 (1) 1

The licensee has failed to ensure that a response was provided within 10 business days of the receipt of the complaint concerning a written complaint made to the DOC and ED concerning the care of a resident, and where the complaint alleged harm or risk of harm to the resident, the investigation was commenced immediately.

Rationale and Summary:

Complainant provided Inspector #577 with copies of two emails forwarded to the home, which contained many care concerns. The email on an identified date, was forwarded to the ED and DOC and contained concerns related to IPAC practises and care concerns,

Review of home's policy "Complaints and Customer Service – RC-09-01-04" reviewed April 2022, indicated that the home would ensure that families/SDMs received a response within the required legislative time frames and the addressed concerns were documented. The home would initiate an investigation into the circumstances leading to the complaint within 24 hours and complete the investigation within ten days; they would provide a written response at the conclusion of the investigation. The written response would include what the home had done to resolve the complaint and the reasons why this conclusion was reached if the complaint was unfounded. And confirmation that the home immediately forwarded the complaint to the Ministry in instances where a written complaint alleges harm or risk of harm, including but not limited to physical harm to one or more residents. They would provide follow up to acknowledge the complaint, inform complainant that an investigation has been initiated/conducted and assure the complainant that a written response would be provided within ten days or sooner.

During an interview with the complainant, they advised that following the email they forwarded the home on an identified date, there was a meeting with the ED to discuss their concerns, but there wasn't a follow up or resolution to their concerns.

During an interview with the ED, they acknowledged receiving an email complaint from the resident's EC on an identified date. They further advised that they met with the EC on An identified date, and discussed their concerns and they were not sure that they had given the EC a response after the investigation.

Sources: Review of two email threads forwarded from the complainant to the DOC and ED, review of home's policy "Complaints and Customer Service – RC-09-01-04" reviewed April 2022, interviews with the complainant, an RN and the ED.

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WRITTEN NOTIFICATION [REPORTING AND COMPLAINTS]

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 108 (1) 2

The licensee has failed to ensure that a documented record was kept in the home concerning an email from an EC sent on an identified date, that included the nature of the written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

Rationale and Summary:

The complainant provided Inspector #577 with copies of two emails on two identified dates, forwarded to the home, which entailed many care concerns. The email on an identified date, was forwarded to the ED and DOC, and entailed concerns related to unsafe care, lack of privacy provided to the resident, and the hygienic and cleanliness of the resident's room.

Review of home's policy "Complaints and Customer Service – RC-09-01-04" reviewed April 2022, indicated that the home would proactively address and resolve concerns/complaints in a

timely manner and the addressed concerns were documented. They were to maintain a record of all complaints and actions taken in the Complaint Log.

During an interview with the ED, Inspector #577 requested records of any complaints received since a specific time period. They stated that they kept all their records electronically in a file and provided the Inspector with a document titled 'Complaint Log' which listed a verbal complaint received on an identified date, from a resident's EC.

Inspector #577 reviewed two completed Complaint Investigation Forms, on two identified dates. There were no records related to an email sent on an identified date, from the EC for a resident to the ED and DOC.

The resident was at risk for further harm when the home failed to investigate a complaint concerning unsafe care.

Sources: Review of two email threads forwarded from the complainant to the DOC and ED, review of home's policy "Complaints and Customer Service – RC-09-01-04" reviewed April 2022, interviews with the complainant and the ED.

[577]

WRITTEN NOTIFICATION [REPORTING AND COMPLAINTS]

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 246/22 s. 108 (3) a

The licensee has failed to ensure the documented record of complaints received was reviewed and analyzed for trends, at least quarterly.

Rationale and Summary:

Inspector #577 requested the home's review of their complaints received for analysis and trends. The inspector reviewed the home's document 'Complaint Action Plan' which listed an analysis and trends of complaint data for the first quarter, over a specified time period.

Review of home's policy "Complaints and Customer Service – RC-09-01-04" reviewed April 2022, indicated that the home was required to monitor the resolution of concerns/complaints monthly to identify trends and opportunities for quality improvement and review trends and actions taken at Resident Care or Continuous Quality Improvement (CQI).

The Executive Director (ED) stated that there was no log kept past a specified time period. They stated complaints were not reviewed and analyzed for trends.

The home failed to monitor the resolution of concerns/complaints and failed to identify trends and opportunities for quality improvement.

Sources: Review of the home's complaint log, review of home's policy "Complaints and Customer Service – RC-09-01-04" reviewed April 2022, an interview with the ED.

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COMPLIANCE ORDER [CO#001] [PREVENTION OF ABUSE AND NEGLECT]

NC#009 Compliance Order pursuant to LTCHA, 2007
Non-compliance with: LTCHA, 2007 [*s. 19 (1)]*

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with LTCHA, 2007 s. 19 (1)

The licensee shall:

A) Ensure that a resident is protected from falls by ensuring that staff follow the resident's care plan when providing care. Ensure a specified number of staff members are present prior to initiating personal care.

B) Provide training to a PSW on safe, proper positioning of residents while providing care to a resident while in their bed.

Grounds

Non-compliance with: LTCHA, 2007 s. 19 (1)

A CIS report was submitted to the Director on an identified date, which alleged staff to resident neglect. The report indicated that the resident's bed was in a particular position when a PSW began to initiate personal care; the resident had a fall and suffered a specific injury. The report indicated that the resident was dependent on staff for a specified intervention.

An anonymous complaint was received by the Director on an identified date, related to care concerns and a resident's fall.

O. Reg. 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

A review of the home's policy, "Zero Tolerance of Resident Abuse and Neglect Program – RC-02-01-01" reviewed January 2022, indicated that Extendicare was committed to providing a safe and secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times. Extendicare had zero tolerance for abuse and neglect and any form of abuse or neglect by any person, whether through deliberate acts or negligence would not be tolerated.

A review of the investigation notes related to the fall of a resident indicated that a PSW had not ensured resident safety during care; the resident's bed was in the incorrect particular position, the PSW had provided care without the specified level of assistance and the resident suffered a specific injury.

A review of the resident's care plan in place on an identified date, indicated that the resident required a specified level of assistance with particular care interventions.

During an interview with a PSW, they advised Inspector #577 that the resident required a specified level of assistance with particular care interventions, and their bed to be in a particular position, which was not provided to the resident. The resident then suffered a specific injury.

During an interview with the ED, they advised that the resident suffered neglect when a PSW provided care without the specified level of assistance and the resident suffered a specific injury.

The home failed to reduce the risk of injury for a resident, by not ensuring adequate assistance prior to initiating care.

Sources: Observations of a resident, review of the CIS report, review of the resident's medical records, review of the home's investigation records, a PSW employee file and training records, the home's policy, "Zero Tolerance of Resident Abuse and Neglect Program – RC-02-01-01" reviewed January 2022, interviews with EC, two PSWs and the ED.

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This order must be complied with by September 9, 2022

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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. Please include the inspection report # and the order or AMP #;
(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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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:

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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
email: 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.