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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 08, 2020	2020_739694_0006 (A1)	021233-19, 024229-19, 000264-20	Follow up

Licensee/Titulaire de permis

CVH (No. 8) 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

Shelburne Long Term Care Home
200 Robert Street SHELBURNE ON L9V 3S1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by AMANDA COULTER (694) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

CDD changed to June 30, 2020.

Issued on this 8 th day of June, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by AMANDA COULTER (694) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): February 18, 19, 21, 24, 25, 26, and 27, 2020.

The following intakes were inspected during this follow up inspection:

Log #024229-19, related to Personal Support Worker (PSW) qualifications and laundry services, Log #000264-20, related to infection control, and Log #021233-19, follow up to CO #001 from inspection 2019_739694_001, related to staffing plan.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), scheduling clerk, laundry and housekeeping staff, and residents.

The Inspector also toured the home, observed the provision of care and services, reviewed relevant documents, including but not limited to clinical records, staff schedules, policies and procedures, and meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Infection Prevention and Control
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.

2 WN(s)
1 VPC(s)
1 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. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents assessed care and safety needs.

This inspection was completed as a Follow up to CO #001 from inspection #2019_739694_0019, related to the home’s staffing plan.

The home’s staffing plan for PSWs showed the following:
Days - eight PSW's working 0600-1400 hours;
Evenings - seven PSW's working 1400-2200 hours and;
Nights - three PSW's working 2200-0600 hours.

PSW hours were reviewed for the specified period and identified that the home had vacant hours that were not worked by PSW staff or agency.

According to the home’s plan, when they were working short, resident care was to be divided among the other PSWs.

During interviews with staff they said PSWs worked short staffed on a regular

basis. Staff said there was no communication with registered staff about the missing baths/showers and rescheduling of the activities.

A) A resident shared that there were occasions when they did not get their shower. The resident said they were told there was not enough staff, they were working short.The resident said they had never refused a shower.

Review of the Point of Care (POC) documentation for this resident showed: They missed four showers during the two months reviewed.

B) Another resident shared that they felt discouraged that they were not getting a minimum of two showers a week because of staff shortages.

Review of the Point of Care (POC) documentation for this resident showed: They missed five showers during the two months reviewed.

C) Another resident shared that they missed their bath often. The resident explained that staff washed them in bed, but their hair did not get washed and they preferred to sit in the tub.

Review of the Point of Care (POC) documentation for this resident showed: They missed seven showers during the two months reviewed.

There was no documentation in these residents clinical records that registered staff were notified and that missed showers were rescheduled.

The home's staffing plan evaluation showed that the home's staffing plan and contingency plans were evaluated in December 2019. The Long-Term Care Home (LTCH) inspector observed and noted in the review that the contingency plan had not been implemented on many occasions.

Staff interviewed said they worked short staffed on a regular basis. Staff expressed they were not able to provide all the care the residents required.

Management acknowledged the home had vacant PSW hours which impacted resident care in January and February, 2020. They had not implemented all steps outlined in their plan and were aware residents were still missing their baths.

The licensee failed to ensure that the staffing plan for nursing and personal

support services provided for a staffing mix that was consistent with resident care needs, specifically bathing. [s. 31. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 47. Qualifications of personal support workers

Specifically failed to comply with the following:

s. 47. (1) Every licensee of a long-term care home shall ensure that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,
(a) has successfully completed a personal support worker program that meets the requirements in subsection (2); and
(b) has provided the licensee with proof of graduation issued by the education provider. O. Reg. 399/15, s. 1.

Findings/Faits saillants :

1. The licensee failed to ensure that every person hired as a personal support worker or to provide personal support services, regardless of title, had successfully completed a personal support worker program that met the requirements and had provided the licensee with proof of graduation issued by the education provider.

A concern was brought to the Ministry of Long-Term Care (MLTC) regarding the qualifications of specific staff members.

Management staff told the LTCH inspector that the specific staff were not qualified to work in PSW positions. The staff were removed from the schedule when the error was discovered.

The licensee failed to ensure that every person hired as a personal support worker or to provide personal support services, regardless of title, had successfully completed a personal support worker program that meets the requirements and had provided the licensee with proof of graduation issued by the education provider. [s. 47. (1)]

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 every person hired as a personal support worker or to provide personal support services, had successfully completed a personal support worker program that meets the requirements and had provided the licensee with proof of graduation issued by the education provider, to be implemented voluntarily.

Issued on this 8 th day of June, 2020 (A1)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by AMANDA COULTER (694) - (A1)
Inspection No. / No de l'inspection :	2020_739694_0006 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	021233-19, 024229-19, 000264-20 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Jun 08, 2020(A1)
Licensee / Titulaire de permis :	CVH (No. 8) 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
LTC Home / Foyer de SLD :	Shelburne Long Term Care Home 200 Robert Street, SHELBURNE, ON, L9V-3S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lisa Thompson

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To CVH (No. 8) 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.), you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2019_739694_0019, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

The licensee must be compliant with s. 31. (3) of the Ontario Regulations 79/10.

Specifically the licensee must:

a) Ensure that the staffing plan for nursing and personal support services provides for a staffing mix that is consistent with resident's assessed care needs, specifically bathing.

b) Ensure residents #002, #003, #004 and any other resident are provided at least two baths/showers per week according to their preference.

c) Ensure the revised staffing plan, including the revised staffing back-up plan, is
implemented and complied with.

Grounds / Motifs :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents assessed care and safety needs.

This inspection was completed as a Follow up to CO #001 from inspection #2019_739694_0019, related to the home's staffing plan.

The home's staffing plan for PSWs showed the following:
Days - eight PSW's working 0600-1400 hours;
Evenings - seven PSW's working 1400-2200 hours and;
Nights - three PSW's working 2200-0600 hours.

PSW hours were reviewed for the specified period and identified that the home had vacant hours that were not worked by PSW staff or agency.

According to the home's plan, when they were working short, resident care was to be divided among the other PSWs.

During interviews with staff they said PSWs worked short staffed on a regular basis. Staff said there was no communication with registered staff about the missing baths/showers and rescheduling of the activities.

A) A resident shared that there were occasions when they did not get their shower. The resident said they were told there was not enough staff, they were working short.The resident said they had never refused a shower.

Review of the Point of Care (POC) documentation for this resident showed:
They missed four showers during the two months reviewed.

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Review of the Point of Care (POC) documentation for this resident showed:
They missed five showers during the two months reviewed.

C) Another resident shared that they missed their bath often. The resident explained that staff washed them in bed, but their hair did not get washed and they preferred to sit in the tub.

Review of the Point of Care (POC) documentation for this resident showed:
They missed seven showers during the two months reviewed.

There was no documentation in these residents clinical records that registered staff were notified and that missed showers were rescheduled.

The home's staffing plan evaluation showed that the home's staffing plan and contingency plans were evaluated in December 2019. The Long-Term Care Home (LTCH) inspector observed and noted in the review that the contingency plan had not been implemented on many occasions.

Staff interviewed said they worked short staffed on a regular basis. Staff expressed they were not able to provide all the care the residents required.

Management acknowledged the home had vacant PSW hours which impacted resident care in January and February, 2020. They had not implemented all steps outlined in their plan and were aware residents were still missing their baths.

The licensee failed to ensure that the staffing plan for nursing and personal support

services provided for a staffing mix that was consistent with resident care needs, specifically bathing. [s. 31. (3)]

The severity of this issue was determined to be a level 2 as there was minimal harm to the residents. The scope of the issue was a level 3, widespread as three of three residents looked at were impacted. The home had a level 4 compliance history as they had on-going non-compliance with this section of the O. Reg. 79/10 and three or fewer compliance orders that included:

Compliance Order (CO) #001 issued on October 15, 2019, with a compliance due date of January 3, 2020 (2019_739694_0019).
(694)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2020(A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 8 th day of June, 2020 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by AMANDA COULTER (694) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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Service Area Office / Bureau régional de services : Central West Service Area Office