

**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**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 18, 2022	2022_829757_0001	019439-21, 020254-21	Complaint

Licensee/Titulaire de permis

CVH (No. 9) 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

Southbridge Lakehead

135 South Vickers Street Thunder Bay ON P7E 1J2

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

DAVID SCHAEFER (757)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 7-10, 2022.

The following intakes were inspected during this complaint inspection:

- a complaint regarding resident care concerns.**
- a complaint related to the home's visitation policy.**

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care (ADOC), Falls Lead, Restorative Care Lead, Behaviour Support Worker, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and a Housekeeper.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, staff-to-resident interactions, resident-to-resident interactions, observed infection prevention and control (IPAC) practices, and reviewed relevant resident health care records, as well as specific licensee policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:

- Dining Observation**
- Falls Prevention**
- Infection Prevention and Control**
- Personal Support Services**

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

- 1 WN(s)**
- 1 VPC(s)**
- 0 CO(s)**
- 0 DR(s)**
- 0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A resident had a fall which resulted in an injury. This fall was documented by a Registered Nurse (RN) only in the resident's progress notes, and an assessment was not completed using a clinically appropriate assessment instrument that was specifically designed for falls. As a result of the failure to complete this post-fall assessment, there was risk that important information related to the fall was not captured which may have been used to mitigate the risk of future falls for the resident. The home's Falls Lead indicated it was their expectation that a post-fall assessment be completed following every fall of a resident.

Sources: A resident's electronic progress notes and post-fall assessments; Interviews conducted with the Administrator, Falls Lead, and an RN. [s. 49. (2)]

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 when a resident has fallen, the resident is assessed and where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 24th day of March, 2022

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

Original report signed by the inspector.