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

Original Public Report

Report Issue Date: March 17, 2023	
Inspection Number: 2023-1445-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: CVH (No. 9) LP by its general partner, Southbridge Care Homes (a limited partnership by its general partner, Southbridge Health Care General Partner, Inc.)	
Long Term Care Home and City: Southbridge Pinewood, Thunder Bay	
Lead Inspector Christopher Amonson (721027)	**Inspector Digital Signature** Christopher E Amonson Digitally signed by Christopher E Amonson Date: 2023.03.24 15:39:25 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 7 – 10, 13, 14 2023

The following intake(s) were inspected:

- Two intakes related to allegations of resident neglect;
- One intake related to complaints of resident neglect; and
- One intake related to complaints of resident care and staffing.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Doors in a home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that all doors leading to non-residential areas must be kept closed and locked when they are not being supervised by staff.

Rationale and Summary
During the inspection, multiple observations were made of non-residential areas, which were noted to have doors propped open with no staff supervising.

Interviews with staff, including the Senior Executive Director, indicated that doors in non-residential areas should be always closed and locked to prevent any negative outcome to a resident.

Sources: LTC home's policy titled "Door Surveillance and Secure Outdoor Areas: OP-04-01-04, last Reviewed: January 2022; observations of home areas in the LTC home; and interviews with staff and Senior ED. [721027]

WRITTEN NOTIFICATION: Dealing with complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 108 (2)

The licensee has failed to ensure that a documented record was kept in the home that included, the nature of each verbal or 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
After reviewing the Long-Term Care (LTC) home's record of complaint logs, it was identified that there was no Complaint Log for one full calendar year.

Senior ED confirmed that they were unable to locate the complaints binder for the year requested. It was also acknowledged by the Senior ED that there should be a complaints process in place that includes maintaining an ongoing record of complaints with any actions taken, written investigation records and any other forms of documentation pertinent to the complaints process.

Sources: LTC home's complaints records; LTC home's policy titled "Complaints and Customer Service: RC-09-01-04", Last Reviewed: April 2022; and interviews with Senior ED. [721027]

WRITTEN NOTIFICATION: Licensee must investigate, respond and act

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (ii)

The licensee has failed to ensure that an alleged incident of neglect of a resident by staff was immediately investigated.

Rationale and Summary
Upon review of the LTC home's investigation records, it was noted that there was no investigation conducted for an alleged incident of abuse towards a resident.

A resident brought forward concerns to staff regarding care they received on a previous shift, however, no follow-up or assessment was done after the alleged incident occurred. Staff acknowledged the incident was brought to their attention by the resident. Senior ED indicated that no investigation was done for the incident.

Sources: Resident health care records; LTC home's investigation files; LTC home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program: RC-02-01-01", last Reviewed: January 2022; interviews with resident, staff and Senior ED. [721027]

WRITTEN NOTIFICATION: Duty to Protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was protected from neglect by staff.

O. Reg. 246/22, s. 7, 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 jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary

A resident was found unattended and staff admitted that they were late checking on the resident, as they normally check on residents at the start of their shift in addition to hourly rounds.

Senior ED acknowledged that staff are to perform routine checks throughout the night, and at least every two hours, which are called Care and Comfort Rounds.

Sources: Resident's health care records; LTC home's investigation file; LTC home's policies titled "Zero Tolerance of Resident Abuse and Neglect Program: RC-02-01-01" last reviewed January 2022, "Care and Comfort Rounds: RC-12-01-06" last reviewed January 2023; interviews with staff and Senior ED. [721027]