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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie 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
May 29, 2020	2020_633577_0007	002310-20	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 Roseview
99 Shuniah Street THUNDER BAY ON P7A 2Z2

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

DEBBIE WARPULA (577)

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 2-6 and 9-10, 2020.

The following intakes were inspected during this Complaint (CO) Inspection:
- One intake related to resident care concerns.

Critical Incident System (CIS) Inspection #2020_633577_0006 was conducted concurrently with this CO Inspection.

During the course of the inspection, the inspector(s) spoke with the the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Resident Assessment Instrument (RAI) Coordinator, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions and resident to resident interactions, reviewed relevant health care records, and various policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention

During the course of this 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. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

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.

a) A complaint was received by the Director on an identified date, related to care concerns of resident #001. The complainant also alleged that because the resident had not received a specified intervention as per their schedule, they had experienced falls.

A review of the home's policy, "Fall Prevention and Management Program, RC-15-01-01", revised December 2019, indicated that if a resident experienced an unwitnessed fall, staff were to have completed a "Clinical Monitoring Record" which entailed an assessment of vital signs, neuro vital signs, pain assessment and changes in behaviour, every hour for four hours, then every eight hours for 72hrs; the neuro vital signs were to have included the resident's level of consciousness, ability to move/handgrips, pupil response. At each shift for 72hrs, staff were required to assess vital signs, pain, bruising, change in functional status, cognitive status and changes in range in motion (ROM).

During a record review, Inspector #577 found that resident #001 had four recent unwitnessed falls over a specified time period. Inspector #577 found that for two of the unwitnessed falls, there were inconsistent assessments and documentation when reviewing the particular assessment records, as follows:

-on an identified date: the progress note indicated that the resident was found on the floor in their room in a particular position at an identified time; the particular assessment record was initiated at an identified time, and completed every hour for four hours; two particular assessments were not reassessed until an identified time, 19 hours after the fall; and another particular assessment was not reassessed until an identified time, the following day;
-on another identified date: the progress note indicated that the resident was found sitting on the floor in a particular area at an identified time; the particular assessment record was initiated at an identified time, and three particular assessments were not reassessed and documented every hour for four hours, and re-initiated 11 hours after the fall.

b) During a record review, Inspector #577 found that resident #004 had four recent falls over a specified time period. Inspector #577 found that there were inconsistent assessments and documentation when reviewing the particular assessments records for the four falls, as follows:

-on an identified date: the progress note indicated that the resident was found on the floor in a particular area at an identified time; the particular assessment record was initiated at a specified time and completed every hour for four hours, then not repeated again until the following day;
-on another identified date: the progress note indicated that the resident was found laying in a particular area at an identified time; the particular assessment record was initiated at an identified time, and the assessments and documentation were not done at the required time, and not completed for the 72hrs consistently;
-on another identified date: the progress note indicated that the resident was found on the floor in a particular area at an identified time; the particular assessment record was initiated at an identified time, completed every hour for four hours; two particular assessments were not completed every eight hours for 72hrs consistently; and
-on another identified date: the progress note indicated that the resident was found on the floor in a particular area in a particular position at an identified time; there was no record of the particular assessment record.

During separate interviews with RPN #104 and RPN #113, they reported to Inspector #577 that staff were required to initiate a particular assessment record after a fall; which included three particular assessments, every hour for four hours and every eight hours for 72 hours.

During an interview, the DOC and Inspector #577 reviewed the inconsistent assessments

and documentation on resident #001 and #004's particular assessment records. They confirmed that staff were not following and implementing the home's Falls Program, as staff had not completed the required particular assessments on the particular assessment records. [s. 48. (1) 1.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

A complaint was received by the Director on an identified date, related to care concerns of resident #001. The complainant also alleged that because the resident had not received a specified intervention, they had suffered falls.

A review of the home's policy, "Plan of Care - LTC-C-60-RVM", revised September 5, 2019, indicated that the plan of care reflected the care provided by staff; each staff member would review the printed care plan to ensure that the care they provided was accurately reflected.

A review of the home's policy, "Care and Comfort Rounds - RC-12-01-06", revised December 2019, indicated that the home would schedule regular care and comfort rounds at set intervals to proactively anticipate resident needs related to pain, positioning, prompted voiding, proximity to personal items and other comfort and safety

issues. The policy further indicated that the frequency would be every two hours, hourly, or other.

A review of resident #001's care plan interventions related to a specific care need, indicated that staff were to offer a specified intervention every two hours to have ensured that they had assistance when required, as the resident would attempt to engage in a specific activity.

A progress note on an identified date, indicated that resident #001 had a fall at an identified time, and had been found in a particular area, had slipped on the wet floor and was in a particular condition.

During observations on an identified date, at an identified time, resident #001 was seated in their specific device in the lounge and told Inspector #577 that they needed to be assisted with a particular intervention. The Inspector approached PSW #114 for assistance. They advised that they assisted the resident with a specified intervention before breakfast and that they assist the resident as needed, when the resident requested assistance with the specified intervention.

In an interview later that same day, PSW #114 and Inspector #577 reviewed resident #001's care plan, specific to an identified intervention. They advised that they were aware that the care plan directed staff to offer assistance with the specified intervention every two hours; they only assisted the resident with a specified intervention before breakfast, and did not have an explanation for why they had not offered assistance with the specified intervention every two hours.

During observations on an identified date, at an identified time, Inspector #577 was in resident #001's room, and they requested assistance with the specified intervention.

During observations on an identified date, at an identified time, Inspector #577 noted RPN #104 transfer resident #001 from the dining room to the lounge, and the Inspector heard the resident request assistance with a specified intervention. During this observation, RPN #104 advised the Inspector that they couldn't assist the resident at the moment, as they were waiting on a float PSW to arrive, as the other PSW was on a break.

In an interview with RPN #104, they advised that staff assist the resident with a specified intervention before breakfast and before lunch. They reported that they're unsure about a

specific schedule, and stated that the resident would advise staff when they needed assistance.

In an interview with PSW #115, they advised that resident #001 was assisted with a specified intervention before and after breakfast, and after lunch. They reported that the resident would advise the staff when they needed assistance.

In an interview with the DOC, they advised that staff were required to be assisting the resident with a specified intervention, according to their care plan. [s. 51. (2) (c)]

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 each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence, to be implemented voluntarily.

Issued on this 2nd day of June, 2020

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBBIE WARPULA (577)
Inspection No. / No de l'inspection :	2020_633577_0007
Log No. / No de registre :	002310-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 29, 2020
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
LTC Home / Foyer de SLD :	Southbridge Roseview 99 Shuniah Street, THUNDER BAY, ON, P7A-2Z2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Joanne Lent

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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. 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.), 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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee must be in compliance with Ontario Regulation (O. Reg.) 79/10, r. 48.
Specifically the licensee must:

a) Conduct a knowledge audit of the direct care staffs' understanding of falls management best practices and policy/program.
b) Retrain registered staff on the home's policy, "Fall Prevention and Management Program, RC-15-01-01", ensuring that the "Post Fall Clinical Pathway" and "Clinical Monitoring Record" is included.
c) The home will maintain a record of the retraining, what the training entailed, who completed the training and when the training was completed.

Grounds / Motifs :

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.

a) A complaint was received by the Director on an identified date, related to care concerns of resident #001. The complainant also alleged that because the resident had not received a specified intervention as per their schedule, they had experienced falls.

A review of the home's policy, "Fall Prevention and Management Program, RC-15-01-01", revised December 2019, indicated that if a resident experienced an unwitnessed fall, staff were to have completed a "Clinical Monitoring Record" which entailed an assessment of vital signs, neuro vital signs, pain assessment and changes in behaviour, every hour for four hours, then every eight hours for 72hrs; the neuro vital signs were to have included the resident's level of consciousness, ability to move/handgrips, pupil response. At each shift for 72hrs, staff were required to assess vital signs, pain, bruising, change in functional status, cognitive status and changes in range in motion (ROM).

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b) During a record review, Inspector #577 found that resident #004 had four recent falls over a specified time period. Inspector #577 found that there were inconsistent assessments and documentation when reviewing the particular assessments records for the four falls, as follows:

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During an interview, the DOC and Inspector #577 reviewed the inconsistent assessments and documentation on resident #001 and #004's particular assessment records. They confirmed that staff were not following and implementing the home's Falls Program, as staff had not completed the required particular assessments on the particular assessment records. [s. 48. (1) 1.]

The decision to issue a Compliance Order (CO) was based on the severity which indicated minimal harm or minimal risk, and the scope which was a pattern. In addition, the home's compliance history which indicated previous unrelated non compliance.
(577)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 01, 2020

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

Ordre(s) de l’inspecteur

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

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

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 29th day of May, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

Service Area Office /
Bureau régional de services : Sudbury Service Area Office