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
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159, rue Cedar Bureau 403
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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
Dec 17, 2020	2020_829757_0031	023451-20, 023659-20, 023734-20, 023827-20	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

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): December 1-4, 2020.

The following intakes were inspected during this complaint inspection:
-a complaint regarding resident care concerns, unmanaged wandering residents, insufficient staffing, and infection prevention and control (IPAC) concerns.
-a complaint regarding resident care concerns, insufficient staffing, and IPAC concerns.
-a complaint regarding concerns related to staffing levels.
-a complaint regarding resident care concerns.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Supporting Director of Care (DOC), Regional Director, Rapid Response Lead, IPAC Specialist, IPAC Extenders, Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Recreational Therapist, and Dietary Aides.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Dietary Aide, two Personal Support Workers (PSWs), and all staff participated in the implementation of the infection prevention and control (IPAC) program.

On December 1, 2020, Inspector #757 observed a Dietary Aide in a breakroom with their mask and face shield on their lap. The door to the breakroom had a sign which stated that staff were to sanitize their face shield prior to taking it off and prior to putting it on, and that both the mask and face shield should be placed in paper bags during staff breaks. On a subsequent observation, the Inspector observed two PSWs in the breakroom with their masks pulled down around their chins.

The inspector confirmed additional instances of proper IPAC procedures not being implemented by staff including missed hand hygiene or improper technique and duration, physical distancing not being maintained, donning and doffing of personal protective equipment (PPE), PPE being worn incorrectly, PPE not being worn into resident rooms, and wearing the same PPE into multiple resident rooms. The home also acknowledged that a shortage of housekeeping staff had led to deficiencies in their ability to properly clean and disinfect the home throughout the outbreak.

Sources: Observations of a Heritage unit breakroom conducted on December 1, 2020; Interviews conducted with the Executive Director, Supporting DOC, Regional Director, IPAC specialists, IPAC extenders, a Dietary Aide, and PSWs. [s. 229. (4)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

Multiple complaints were received by the Director with resident care concerns after the onset of the COVID-19 outbreak in the home on November 17, 2020. These concerns included late meals, insufficient resident wellness checks, unmanaged wandering residents during outbreak isolation, inadequate hydration, delayed continence care, and calls bells not being promptly answered. The home acknowledged the care issues that occurred during this period, adding that the inability to sufficiently manage wandering residents was likely a contributing factor in the spread of COVID-19 within the home.

Interviews with PSWs and Nursing staff in the home indicated that the workload for staff had increased substantially due to the need to don and doff PPE each time they entered and exited a room. The PSW staff indicated that they did not have a sufficient number of co-workers to sufficiently manage the care needs of residents following the onset of the COVID-19 outbreak. On November 25, 2020, the home had significantly increased the staffing complement of PSWs in the home.

Sources: Staffing records; Interviews with four complainants; Interviews with the Executive Director, Supporting Director of Care (DOC), and relevant nursing and personal support staff. [s. 8. (1) (b)]

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 there is an organized program of personal support services for the home to meet the assessed needs of the residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was kept clean and sanitary.

The home identified that they had a shortage of housekeeping staff following the onset of the COVID-19 outbreak and that other staff had been assisting with cleaning, but were not as well trained in cleaning procedures as the regular housekeeping staff. The home acknowledged that the shortage had lead to deficiencies in the home's ability to properly clean and disinfect the home.

Sources: Staffing Records; Interviews with the Executive Director, IPAC specialist, and other relevant staff. [s. 15. (2) (a)]

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 the home is kept clean and sanitary, to be implemented voluntarily.

Issued on this 5th day of January, 2021

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) :	DAVID SCHAEFER (757)
Inspection No. / No de l'inspection :	2020_829757_0031
Log No. / No de registre :	023451-20, 023659-20, 023734-20, 023827-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 17, 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

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

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. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Order / Ordre :

The licensee must comply with s. 229 (4) of Ontario Regulation 79/10.

Specifically, the licensee must:

A) Conduct daily documented infection prevention and control (IPAC) procedure audits for staff on each home unit.

B) The audits must include, at a minimum, the following areas: Hand washing, personal protective equipment (PPE), physical distancing, staff breakrooms, and housekeeping.

C) The audits must continue until a minimum of 95 percent overall compliance has been achieved for 30 consecutive days.

Grounds / Motifs :

1. The licensee has failed to ensure that a Dietary Aide, two Personal Support Workers (PSWs), and all staff participated in the implementation of the infection prevention and control (IPAC) program.

On December 1, 2020, Inspector #757 observed a Dietary Aide in a breakroom with their mask and face shield on their lap. The door to the breakroom had a sign which stated that staff were to sanitize their face shield prior to taking it off and prior to putting it on, and that both the mask and face shield should be placed in paper bags during staff breaks. On a subsequent observation, the Inspector observed two PSWs in the breakroom with their masks pulled down around their chins.

The inspector confirmed additional instances of proper IPAC procedures not

being implemented by staff including missed hand hygiene or improper technique and duration, physical distancing not being maintained, donning and doffing of personal protective equipment (PPE), PPE being worn incorrectly, PPE not being worn into resident rooms, and wearing the same PPE into multiple resident rooms. The home also acknowledged that a shortage of housekeeping staff had led to deficiencies in their ability to properly clean and disinfect the home throughout the outbreak.

Sources: Observations of a Heritage unit breakroom conducted on December 1, 2020; Interviews conducted with the Executive Director, Supporting DOC, Regional Director, IPAC specialists, IPAC extenders, a Dietary Aide, and PSWs.

An order was made by taking the following factors into account:

Severity: Proper infection prevention and control procedures were not followed by staff throughout the home. This resulted in increased risk for the spread of COVID-19 to residents living in the home during an active COVID-19 outbreak.

Scope: There was a demonstrated pattern of non-compliance related to this issue.

Compliance History: The home had no history of non-compliance to this sub-section of the legislation in the past 36 months. (757)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2021

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:

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 17th day of December, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : David Schaefer

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