Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Sudbury Service Area Office
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
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Original Public Report

Report Issue Date June 29, 2022
Inspection Number 2022_1351_0001
Inspection Type
☐ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☒ Other Infection Prevention and Control (IPAC)

Licensee
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

Long-Term Care Home and City
Southbridge Roseview, Thunder Bay

Lead Inspector
Chad Camps #609

Additional Inspector(s)
Ryan Goodmurphy #638

Inspector Digital Signature
Chad A Camps Digitally signed by Chad A Camps
Date: 2022.07.13 11:19:33 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 9-12, 2022

The following intake(s) were inspected:

- One complaint related to monitoring of residents
- One complaint related to wound care and staffing levels
- Two complaints related to the home's staffing levels
- One complaint related to the care of residents

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Resident Care and Support Services
- Skin and Wound Prevention and Management

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

WRITTEN NOTIFICATION PLAN OF CARE

NC #01 Written Notification pursuant to Fixing Long Term Care Act (FLTCA), 2021, section (s.) 154(1)1

Non-compliance with: Ontario Regulation (O. Reg.) 246/22 s. 29. (3) 21

The licensee has failed to ensure that residents' plans of care were based on, at a minimum, interdisciplinary assessment with respect to the residents' sleep patterns and preferences.

Rationale and Summary

a) In a home area that was short Personal Support Workers (PSWs) during a shift, a resident was seen in distress, asking to go back to bed. The resident's plan of care found no mention of the resident's sleep patterns or preferences.

b) Related to shortages of staff in a home area, a resident was assisted to bed almost two hours past their typical bedtime. PSW staff acknowledged that the resident's sleep patterns should have been identified in their plan of care. The resident's plan of care found no mention of when the resident's typical bedtime was.

c) A resident's Substitute Decision Maker (SDM) requested the resident be assisted to bed. Due to shortages of staff in the home area the resident was assisted to bed at approximately one and a half hours later. The resident's plan of care found no mention of the resident's sleep patterns or preferences.

The Acting Executive Director (ED) verified that residents should be assisted to bed at the time of their choosing and that care was delayed due to shortages of staff.

There was moderate harm to one resident whose plan of care did not specify their sleep patterns and whose bedtime care was delayed as well as potential harm to all other residents whose sleep patterns and preferences were not identified, nor implemented in their plans of care.

Sources: Plans of care for resident three residents; interviews with the SDM for a resident; the ED; and other relevant staff. (609)

WRITTEN NOTIFICATION PLAN OF CARE

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6. (9) 1

1) The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Rationale and Summary

During a shift in a home area, a single PSW was working in the home area because of a staffing shortage. As a result of the shortage and the resulting time constraints, they did not complete any Point of Care (POC) charting. POC documentation on the shift found no charting was completed on any of the residents.

The ED verified that documentation of the provision of care should have been completed but admitted that because of the staffing shortage on the shift, the care of the residents was the priority over documentation.

Sources: The home's policy titled "Health Care Record" last reviewed January 2022; POC charting for a home area; interviews with the ED; and other relevant staff. (609)

2) The licensee has failed to ensure that that the provision of the care set out in the plan of care was documented.

Rationale and Summary

A resident described how they required wound care and that staff had not managed their wound as required. The electronic Treatment Administration Record (eTAR) identified that the resident was scheduled for wound care on two dates. Neither of the dates had documentation to identify if the wound care had been done or not.

The Inspector was unable to determine if staff completed the scheduled wound care or not as they should have recorded if the care had or had not been done.

Sources: A resident's health care records; progress notes; eTAR; interviews with the ED; and other relevant staff. (638)

3) The licensee has failed to ensure that that the provision of the care set out in the plan of care was documented.

Rationale and Summary

a) POC documentation records from a night shift in a home area identified that all residents lacked documentation.

A resident's POC records from the night shift identified that they lacked documentation regarding multiple care areas.

b) The POC documentation records during a 24-hour period were reviewed and found;

Day shift;
-Four home areas had more than 50 per cent of all residents with missing POC documentation.

Evening shift;
-Five home areas had 20 per cent or more of residents with missing POC documentation.

Night shift;
-Four home areas had 30 per cent or more of residents with missing POC documentation. .

A resident's POC records on the day and evening shifts identified that there was no documentation regarding multiple care areas.

The ED stated that staff were expected to document the care they provided and that they could not say for sure if care was done or not.

There was low risk to residents when the documentation of their provision of care was not completed.

Sources: POC electronic care records for two days; a resident's POC electronic care records for two days; document titled "Role Profile: Personal Support Worker"; interviews with the ED; and other relevant staff. (638)

WRITTEN NOTIFICATION FALLS PREVENTION AND MANAGEMENT

NC# 03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *s. 54 (2)*

The licensee has failed to ensure that when a resident fell, they were assessed using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary

A resident had an unwitnessed fall that a progress note verified had occurred. The Inspector and ED reviewed the resident's care records and were unable to identify that a post fall assessment tool had been completed.

There was low risk of harm to the resident whose post falls assessment was not completed.

Sources: A resident's progress notes; POC assessments tab; the home's policy titled Falls Prevention and Management Program #RC-15-01-01 last revised January 2022; interviews with the ED; and other relevant staff. (638)

COMPLIANCE ORDER (CO) #001 CMOH AND MOH

NC #04 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 *s. 272*

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 272

The licensee shall:

a) Complete a documented update of the home's Outbreak Preparedness Plan to ensure that it is consistent with Public Health Ontario (PHO) direction and that all staff identified in the Outbreak Preparedness Plan are still employed in the home and are aware of their roles and responsibilities;
b) Maintain a record of when, who and what direction the home receives from Public Health related to the home's Outbreak Preparedness Plan, its implementation and/or any guidance contrary to the plan;
c) Conduct a documented retraining of all direct care staff, on the home's droplet/contact precautions;
d) Conduct a documented Case Mix Index (CMI) reassessment of every home area and update the home's staffing plan to ensure that the staffing levels are adequate to provide safe, appropriate care to residents;
e) Incorporate documented feedback on the CMI reassessment and any updates to the staffing plan from PSWs, Registered Practical Nurses (RPNs) and Registered Nurses (RNs) working in the home;
f) Certify that the CMI reassessment and updated staffing plan account for the additional time required for staff to adhere to COVID-19's additional precautions, including but not limited to donning and doffing required PPE;
g) Conduct a documented review of the updated staffing plan to ensure that the staffing levels are adequate to provide safe, appropriate care to residents, at a minimum weekly for three months; and
h) Maintain a record within the three-month review of what strategies the home trialled and/or implemented to respond to the updated staffing plan.

Grounds

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Non-compliance with: O. Reg. 246/22 s. 272

1) The licensee has failed to ensure that directives issued by the Chief Medical Officer of Health, specifically Directive #3, implementing a COVID-19 Outbreak Preparedness Plan was followed in the home.

Rationale and Summary
A PSW was working on a COVID-19 outbreak home area. After a 72-hour leave of absence the home's Acting Director of Care (DOC) instructed the PSW to return to work on a non-outbreak home area.

The home's COVID-19 Outbreak Preparedness Plan directed the home to ensure that staff remained cohorted to the outbreak home areas for the duration of the outbreak, which was consistent with the direction from Public Health Ontario (PHO).

Thunder Bay Public Health indicated that their expectation was that staff remained cohorted for the duration of the outbreak and did not provide the home with allowances to clear staff to move between COVID-19 outbreak to non-outbreak home areas.

There was actual risk to residents when the Acting DOC did not comply with the home's Outbreak Preparedness Plan and did not cohort the PSW to an outbreak home area for the duration of the outbreak.

Sources: The home's Outbreak Preparedness Plan; COVID-19 Directive #3 for Long-Term Care Homes under the Fixing Long-Term Care Act, 2021, issued to the May 03, 2022; PHO's Cohorting in Outbreaks in Congregate Living Settings 2nd Revision: March 2022; and interviews with the Acting IPAC Lead; Public Health; and other relevant staff. (609)

2) The licensee has failed to ensure that directives issued by the Chief Medical Officer of Health, specifically Directive #5, staff donning and doffing droplet/contact PPE, was followed in the home.

Rationale and Summary

During the lunch meal service in the COVID-19 isolated home area, the Inspector observed a PSW enter a resident's room and set up their meal. The resident's signage outside their room required staff to don droplet/contact PPE when entering and doff the PPE when leaving the room. The PSW entered the room, handled the resident's belongings to make room for the meal tray and was within one foot of the resident all while wearing a mask and face shield. The PSW admitted to the Inspector that they should have been wearing the additional PPE (gloves and gown) when they entered the resident's room.

During a tour of the home, the Inspector observed a COVID-19 isolated home area, where a PSW was providing hands on morning care to a resident without additional PPE (gloves and gown). The resident's signage outside the room indicated that the resident was on droplet/contact precautions and staff were required to don and doff PPE to enter the room. The

PSW admitted they should have been donning and doffing PPE but described how they were the only PSW for half the home area and were trying to get residents ready for breakfast during the busiest time of the day for care.

As per Directive #5 issued to the home, for regulated health professionals and other health care workers in a long-term care home, Droplet and Contact Precautions must have been used for all interactions with suspected, probable, or confirmed COVID-19 residents. The Acting IPAC Lead and ED verified that the PSWs should have followed the isolation signage and donned and doffed the required additional PPE when caring for COVID-19 isolated residents.

There was actual risk to residents related to inadequate staffing on COVID-19 outbreak home areas and staff's inability to adequately don and doff required PPE.

Sources: Observations on two days; droplet/contact precautions signage outside residents' rooms; COVID-19 Directive #5 for Hospitals within the meaning of the Public Hospitals Act and Long-Term Care Homes within the meaning of the Long-Term Care Homes Act, 2007, issued December 17, 2021; and interviews with the Acting IPAC Lead; the ED; and other relevant staff. (609)

This order must be complied with by September 22, 2022

CO #002 SKIN AND WOUND CARE

NC #05 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 55. (2) (b)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 55. (2) (b)

The licensee shall:

a) Conduct a documented retraining of all registered staff on the home's skin and wound assessment processes; and
b) Conduct a documented review of all residents who have active wounds to ensure that they have weekly wound assessments completed using a designated skin and wound assessment tool.

Grounds

Non-compliance with: O. Reg. 246/22 s. 55. (2) (b)

1) The licensee has failed to ensure that a resident's exhibited altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

A resident was identified as exhibiting altered skin integrity. The area was initially assessed and recorded, however, there was no follow up assessment regarding the resident's altered skin integrity. Registered staff outlined that they were required to conduct a follow up assessment on altered skin integrity at least weekly and this was documented in point click care assessments.

There was no additional update or assessment of the resident's altered skin integrity's progression after the initial assessment was completed.

Sources: A resident's progress notes; eMAR; point click care assessment; policy titled: Skin and Wound Management – RC-23-01-02 – last revised January 2022; and interviews with the ED; and other relevant staff. (638)

2) The licensee has failed to ensure that a resident's exhibited altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

A resident was identified as exhibiting altered skin integrity and found that there was no documentation to identify an assessment had occurred to monitor the progression of the resident's altered skin integrity with gaps of multiple weeks on multiple occasions. Registered staff outlined that they were required to conduct a follow up assessment on altered skin integrity at least weekly and this was documented in point click care assessments.

There was moderate risk of harm to two residents when multiple weeks of skin and wound assessments were not completed on their exhibited altered skin integrity.

Sources: A resident's progress notes; electronic medication administration records; point click care assessment; policy titled: Skin and Wound Management – RC-23-01-02 – last revised January 2022; and interviews with the ED; and other relevant staff. (638)

This order must be complied with by September 22, 2022

CO#003 INFECTION PREVENTION AND CONTROL PROGRAM

NC #06 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 246/22 s. 102. (2) (b)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 102. (2) (b)

The licensee shall:

a) Complete a documented retraining of all direct care staff on the home's Hand Hygiene Guide and the importance of hand hygiene for residents prior to eating their meals; and
b) Conduct a documented review to ensure staff aids or encourages all residents to clean their hands prior to eating their meals, at a minimum weekly for three months or longer, until no concerns with adherence are identified and/or have not been remedied.

Grounds

Non-compliance with: O. Reg. 246/22 s. 102. (2) (b)

The licensee has failed to ensure that the Standard issued by the Director with respect to IPAC was implemented.

Rationale and Summary

Despite the home's Hand Hygiene (HH) Guide and the IPAC Standard for Long-Term Care Homes, which required staff to aid or encourage residents to clean their hands before meals, three PSWs served lunch meals to three residents without HH being aided or encouraged in a COVID-19 outbreak home area.

A PSW admitted that they did not aid or encourage HH to residents prior to serving them their meals. The ED and the Acting IPAC Lead verified that it was the expectation that HH be aided or encouraged to residents before eating their meals, but that this has been a "challenge" for the home.

There was actual risk to residents related to the possible transmission of disease-causing organisms and specifically COVID-19 that may have been on their hands.

Sources: Observations of the lunch meal service in a home area; the home's Hand Hygiene Guide, 2021; Infection Prevention and Control Standard for Long-Term Care Homes April 2022; Just Clean Your Hands Implementation Guide Ontario's step-by-step guide to implementing a hand hygiene program in your long-term care home Catalogue No. 011816 3M September 2009; and interviews with the Acting IPAC Lead; the ED; and other relevant staff. (609)

This order must be complied with by September 22, 2022

CO #004 PLAN OF CARE

NC #07 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 s. 6. (7).

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with s. 6. (7)

The licensee shall:

a) Conduct a documented review to ensure staff are present and providing supervision at all specified times, for every resident who requires particular monitoring, at a minimum weekly for three months or longer, until no concerns with adherence are identified and/or have not been remedied.

Grounds

Non-compliance with: FLTCA, 2021 *s. 6 (7)*

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan.

Rationale and Summary

A resident required a particular monitoring at specified times due to responsive behaviours. On two instances the resident did not have staff assigned for the monitoring. The resident was administered pharmacological interventions which were deemed ineffective after administration.

Direct care staff identified that the resident required the monitoring to help calm the resident as they had responsive behaviours.

There was moderate risk of harm to residents related to the resident's responsive behaviours when the resident's particular monitoring was not provided.

Sources: A resident's progress notes; electronic medication administration record (eMAR); plan of care; and interviews with the ED and other relevant staff. (638)

This order must be complied with by September 22, 2022

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

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