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

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|---|---|
| **Report Issue Date:** November 15, 2023 | |
| **Inspection Number:** 2023-1445-0002 | |
| **Inspection Type:**<br>Complaint<br>Critical Incident | |
| **Licensee:** CVH (No. 9) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.) | |
| **Long Term Care Home and City:** Southbridge Pinewood, Thunder Bay | |
| **Lead Inspector**<br>Shelley Murphy (684) | **Inspector Digital Signature**<br>Shelley Murphy Digitally signed by Shelley Murphy Date: 2023.11.15 09:06:50 -05'00' |
| **Additional Inspector(s)**<br>Oraldeen Brown (698) | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 16-20, 2023.

The following intake(s) were inspected:

- One intake related to responsive behaviours;
- Two intakes related to alleged resident neglect;
- One intake related to a missing resident; and,
- One intake related to resident to resident physical abuse.

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

Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Safe and Secure Home

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 5

The licensee failed to ensure that the home was a safe and secure environment for a resident.

**Rationale and Summary:**
A Critical Incident (CI) was submitted to the Director on a specified date related to an incident involving a resident.

Staff did not activate the safety plan when they became aware of the incident which put a resident at risk. The home's policy indicated that as soon as the safety risk was noted the safety plan was to be put in place.

Two staff members and the DOC acknowledged that safety plan was not activated as per the home's policy when the staff became aware of the incident. Staff's failure to activate the safety plan, put the resident at moderate risk for injury.

**Sources:** CIS report; Code Yellow Policy; the home's investigation file; resident's health care record including care plan and progress notes, interviews with the Director of Care (DOC) and other relevant staff.
[698]

## WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 24 (1)

**Rationale and Summary**
The licensee failed to protect a resident from abuse by anyone and ensure that the resident was not neglected by the licensee or staff.

A CI for improper/incompetent treatment of a resident that results in harm or risk to a resident, indicated that a resident care intervention was not followed.

Upon review of the home's investigation notes, there was a typed document which confirmed that neglect had occurred.

The DOC was interviewed and stated it was founded that the staff member did not do complete resident care as per policy and procedure and that the employee was neglectful.

This was moderate risk for the resident, the resident had no ill effects from the incident.

**Sources**: CI report, Resident chart, care plan, observations of the resident, home's policy "Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct, home's investigation file and, staff interviews.
[684]