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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: October 16, 2024	
Inspection Number: 2024-1253-0003	
Inspection Type: Proactive Compliance Inspection	
Licensee: CVH (No. 8) 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: Shelburne Long Term Care Home, Shelburne	
Lead Inspector	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 17-19, 23-27, 2024 and October 1-2, 2024.

The following intake(s) were inspected:

- Intake: #00126693 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Residents' and Family Councils

Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Staffing, Training and Care Standards
Residents' Rights and Choices
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Air temperature

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 24 (3)

Air temperature

s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee failed to ensure that the temperature was documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m., and once every evening or night.

Rationale and Summary

A review of the home's air temperature tracking sheets for September 2024, indicated that the temperature was not taken at the required time on three occasions.

The temperature was not taken during the evening or night on September 7 and 17,

2024 and on the morning of September 10, 2024.

The Associate Director of Care (ADOC) acknowledged that the temperature recordings were not documented..

There was risk for resident discomfort when the air temperatures were not recorded at the required times.

Sources: Air Temperature Tracking Sheets September 2024; Interview with the ADOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by an authorized person described in subsection (2.1), if clinically indicated;

The licensee failed to ensure that a resident, who was exhibiting altered skin integrity, was reassessed at least weekly by a member of the registered nursing staff, as clinically indicated.

Rationale and Summary

A review of a residents progress notes indicated that the resident had a new area of skin alteration.

A registered practical nurse (RPN) documented in a progress note that they were unable to reassess the wound due to workload.

The wound was not reassessed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment until two weeks after the first reassessment.

A RPN stated that wounds are reassessed weekly until they are healed and that the wound should have been reassessed.

There may have been increased risk of the wound worsening as it was not reassessed weekly.

Sources: Residents progress notes, Interview with RPN,

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to implement the IPAC Standard, last revised September 2023, when staff did not complete hand hygiene (HH) at the four moments of HH.

In accordance with the Additional Requirements in the IPAC Standard section 9.1 (b)

staff are expected to perform HH, including, but not limited to, at the four moments of HH.

Rationale and Summary

On October 1, 2024, it was observed that a Maintenance staff member was in a residents room and in contact with the resident's environment. Maintenance staff member then exited the room without performing HH. Maintenance staff member reentered and exited the residents room two more times without performing HH after being in contact with the resident's environment.

The Infection Prevention and Control (IPAC) Lead stated that HH is to be done for routine practices.

The home's HH policy stated that staff are to perform HH before resident/resident environmental contact, and after resident/resident environmental contact.

When staff did not complete HH, there was a risk of transmission of infectious agents.

Sources: Observations, Interview with IPAC Lead, HH Policy

WRITTEN NOTIFICATION: Quarterly Evaluation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)
Quarterly evaluation
s. 124 (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator,

the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 246/22, s. 124 (1).

The licensee has failed to ensure that the Medical Director was present for the quarterly Medication Management System evaluation.

Rationale and Summary

On September 24, 2024, there was a quarterly Professional Advisory Committee (PAC) meeting to evaluate the effectiveness of the medication management system in the home. The Medical Director did not attend this meeting.

When all the required members were not included in the quarterly evaluation, suggestions for improvement from all required persons could not be considered.

Sources: Interview with DOC, July PAC Meeting Minutes

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 168 (3)
Continuous quality improvement initiative report
s. 168 (3) The licensee shall ensure that a copy of the report is provided to the Residents' Council and Family Council, if any.

The licensee failed to ensure that a copy of the Continuous Quality Improvement (CQI) report was provided to the Residents' Council (RC) and Family Council (FC), if

any.

Rationale and Summary

A review of the RC and FC meeting minutes did not indicate that the CQI report was provided to the RC and FC.

The Executive Director (ED) stated that a copy of the CQI report was not provided to the RC and the FC.

A resident confirmed that the RC had not been provided with a copy of the CQI report.

A FC member stated that the FC had not been provided with a copy of the CQI report.

By not being provided the CQI report, the RC and FC could not provide feedback.

Sources: RC meeting minutes; FC meeting minutes; Interview with the ED, a resident and a Family Council Member.