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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: May 31, 2023

Inspection Number: 2023-1702-0002

Inspection Type:
Other
Complaint
Critical Incident System

Licensee: CVH (No. 3) 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 London, London

Lead Inspector	**Inspector Digital Signature**
Rhonda Kukoly (213)	Rhonda Kukoly Digitally signed by Rhonda Kukoly Date: 2023.06.01 11:21:28 -04'00'

Additional Inspector(s)
Brandy MacEachern (000752)
Melanie Northey (563)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 23, 24, 25, 26, 2023

The following intake(s) were inspected:

- Intake: #00006946, critical incident #3059-000001-22, related to a fall
- Intake: #00011593, critical incident #3059-000002-22, related to a fall
- Intake: #00013831, critical incident #3059-000003-22, related to a fall
- Intake: #00014931, critical incident #3059-000005-22, related to a fall
- Intake: #00018732, critical incident #3059-000001-23, related to an altercation between residents
- Intake: #00020346, critical incident #3059-000002-23, related to a fall
- Intake: #00083980, a complaint related to food quality and oxygen
- Intake: #00085137, critical incident #3059-000005-23, related to a fall
- Intake: #00085776, critical incident #3059-000006-23, related to a fall
- Intake: #00087917, critical incident #3059-000007-23, related to a fall

- Intake: #00088086, a follow-up to Compliance Order #002 from inspection #2022-1702-0001 related to dining and snack service with original compliance due date November 6, 2022, issued prior to subsequent licensee change on November 18, 2022
- Intake: #00088084, a follow-up to Compliance Order #001 from inspection #2022-1702-0001 related to dining and snack service with original compliance due date November 6, 2022, issued prior to subsequent licensee change on November 18, 2022

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

- Compliance Order #001 from 2022-1702-0001, related to dining and snack service, with original compliance due date November 6, 2022, issued prior to subsequent licensee change on November 18, 2022
- Compliance Order #002 from inspection #2022-1702-0001, related to dining and snack service, with original compliance due date November 6, 2022, issued prior to subsequent licensee change on November 18, 2022

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was remedied by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that a resident's plan of care provided clear directions to the staff and others who provide direct care to the resident.

Rational and Summary:
There was conflicting information in the resident's care plan and kardex related to the level of assistance they required for mobility. The care plan and kardex were then updated and provided clear direction.

Sources: Health records for a resident, unit binders for direct care staff, and staff interviews. [000752]

Date Remedy Implemented: May 26, 2023

WRITTEN NOTIFICATION: Based on assessment of resident

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (2)

The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident.

Rationale and Summary
A resident sustained an injury and an injury specific assessment was first completed over 18 hours following the injury. The Director of Care said that the assessment should have been initiated immediately after their injury. There was risk that harm was not identified, and appropriate treatment provided, when the assessment was not initiated until over 18 hours after being injured.

Sources: Health records for a resident and staff interviews [213]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 the resident as specified in the plan.

Rationale and Summary
A resident had specific directions related to a treatment that were based on regular testing and adjustment of the treatment based on the results of the test. Staff documented the results of the test, but there was no documentation of adjustment of the treatment, and staff were unsure of how to adjust the treatment. There was risk to the resident when the test results were higher than the level recommended by the physician, and the treatment was not adjusted.

Sources: Health records for a resident and staff interviews. [213]