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
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London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: March 27, 2024
Inspection Number: 2024-1702-0001
Inspection Type: Complaint Critical Incident
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**
Ali Nasser (523)	Ali Nasser Digitally signed by Ali Nasser Date: 2024.03.28 09:44:09 -04'00'

Additional Inspector(s)
Henry Otoo (000753)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 22, 23, 24, 25, 26, 29, 2024

The following intake(s) were inspected:
- Intake: #00097646, related to unexpected death of a resident.
- Intake: #00098041, related to unexpected death of a resident.
- Intake: #00100251, complaint related to food production and other care concerns.
- Intake: #00100925, complaint related to care concerns.
- Intake: #00103614, related to a resident's fall.
- Intake: #00106955, related to resident's injury and change in condition.

- Intake: #00107205, Complaint related to staffing concerns.

The following intakes were completed in this inspection:
Intake: #00099907, related to a resident's fall.

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

Resident Care and Support Services
Continence Care
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Doors in a home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,

The licensee failed to ensure that all doors leading to areas that residents do not have access to were kept closed and locked.

Rationale and Summary
During inspection the inspector observed that a tub room door was opened and there were no residents or any staff in the tub room. Inspector walked through the tub room and saw cleaning supplies on the countertop with no lid and two more on the bath tub that were all accessible to anyone who enters.

Two registered nursing staff said during interviews that the PSWs were to close the tub room after use. By leaving the tub room door opened, there was risk for resident(s) wandering into the room and gaining access to and ingesting harmful chemicals or falling and injuring themselves.

Sources: Observation and staff interviews. [000753]

WRITTEN NOTIFICATION: Doors in a home

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee failed to ensure that all doors leading to non-residential areas were

kept closed and locked when they were not being supervised by staff.

Rationale and Summary
During inspection the inspector observed that keys to the laundry chute and other restricted areas to residents and visitors were in the door lock on the door in a common area.
When interviewed, a PSW responsible said their hands were full of laundry, so they left the keys in the door lock.

By leaving the keys in the door of the laundry chute risked that resident(s) or visitor(s) with restricted access could have gained access with potential injury.

Sources: Observation and staff interview. [000753]

WRITTEN NOTIFICATION: Staffing Plan

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 35 (4)
Nursing and personal support services
s. 35 (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee has failed to ensure a written record was kept relating to each annual staffing plan evaluation under clause (3) (e) that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Rational and summary
The Ministry of Long-Term Care received multiple complaints related to changes in the staffing plan.

The Administrator provided inspectors with a staffing plan dated as revised January 2024.

In an interview the Administrator said they reviewed the staffing plan with their corporate office and implemented changes to the staffing plan at the beginning of January 2024. They did not have a written record of the annual evaluation of the staffing plan that resulted in implementing those changes.

Sources: staff interviews and record reviews. [523]

WRITTEN NOTIFICATION: Dining and snack service

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee failed to ensure that food was being served at a temperature that was palatable to residents.

Rationale and Summary
During inspection the inspector observed during lunch that a resident did not receive their meal until 45 minutes past the time lunch started and all their table mates had their meal. The resident did not eat the meal because they said the food was cold, and hard.

Not being provided a meal when everyone else on their table had received their meals and eaten, upset the resident and in addition the food served was cold and not palatable to the resident. This affected their food intake for the day and made them upset.

Sources: Observation, resident interview, and staff interview. [000753]