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: September 5, 2024
Inspection Number: 2024-1702-0003
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 27, 29, 2024
The inspection occurred offsite on the following date(s): August 28, 2024

The following intake(s) were inspected:

- Intake #00119160 related to complaint about room temperatures
- Intake #00119476/ Critical Incident System (CIS) #3059-000020-24 related to flooding
- Intake #00120107/ CIS #3059-000021-24 related to alleged improper treatment of a resident
- Intake #00121747/ CIS #3059-000023-24 related to flooding
- Intake #00123148/ CIS #3059-000025-24 related to an Outbreak

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #001 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.

The licensee failed to ensure the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022, issued by the Director, was implemented.

1) The licensee failed to ensure the proper signage were in place for three residents as required by IPAC Standard.

Rationale and Summary

Three residents in an outbreak area with symptoms did not have the correct signage. The IPAC Lead confirmed staff did not use the correct signage.

Without the correct signage there was risk of infection spreading.

2) The licensee failed to ensure staff understood and used the correct definitions of specific diseases for three residents as required by IPAC Standard.

Rationale and Summary

Three symptomatic residents were not included in an outbreak surveillance data. The IPAC Lead confirmed the three residents should have been included in the outbreak surveillance data.

There was risk of the local Public Health Unit using inaccurate data when making outbreak decisions.

Sources: observations; record review of the home's outbreak surveillance tool; residents' clinical records; and interviews with staff.

WRITTEN NOTIFICATION: Monitoring of Residents for Symptoms of Infection

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)
Infection prevention and control program
s. 102 (9) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with any standard or protocol issued by the Director under subsection (2)

The licensee failed to ensure a resident was monitored for symptoms of infection during every shift.

Rationale and Summary

A resident who was confirmed to have an infection was not monitored for symptoms for three evenings.

The IPAC Lead confirmed the home missed monitoring the resident.

Not monitoring the resident for signs of infection every shift risked impacting their health and well-being negatively.

Sources: review of resident clinical records and interview with IPAC Lead.

WRITTEN NOTIFICATION: Reports Re Critical Incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee failed to ensure the Director was immediately informed of a disease outbreak.

Rationale and Summary
The home delayed reporting an infection outbreak to the Director.

The IPAC Lead acknowledged the home delayed reporting the outbreak to the Director.

Sources: Critical Incident System report and interview with IPAC Lead.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 2. iv.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following

incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
iv. flooding.

The licensee failed to ensure that the Director was informed of flooding in the home no later than one business day after the occurrence of the incident.

Rationale and Summary
The home delayed reporting two flooding incidents to the Director.

The Director of Care confirmed the dates of the flooding incidents and the dates they were reported.

Sources: Critical Incident System reports and staff interview.