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: March 18, 2024

Inspection Number: 2024-1703-0002

Inspection Type:
Complaint
Critical Incident
Follow up

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 Owen Sound, Owen Sound

Lead Inspector	**Inspector Digital Signature**
Daniela Lupu (758)	Daniela Lupu Digitally signed by Daniela Lupu Date: 2024.03.28 12:49:28 -04'00'

Additional Inspector(s)
Janis Shkilnyk (706119)
Katy Harrison (766)
Craig Michie (000690)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 13-16, 20-23, and 26-27, 2024

The following intake(s) were inspected:

- Intake #00102451, and #00106798, related to allegations of neglect and care concerns
- Intake #00102548, related to a medication incident

- Intake #00103158, related to the use of glucagon
- Intake #00104241, related to injuries of unknown cause
- Intake #00108491, related to care concerns
- Intake #00104855, Follow-up to Compliance Order (CO) #001, related to medication administration
- Intake #00106594, related to concerns about staffing, call bells and menu planning
- Intake #00106788, related to care concerns and resident rights
- Intak #00107191, and #00107338, related to care concerns
- Intake #00107594, related to care concerns, staff training and contingency plans.
- Intake #00107888, related to care concerns
- Intake #00109313, related continence care and housekeeping concerns

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1703-0005 related to O. Reg. 246/22, s. 140 (2) inspected by Katy Harrison (766)

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

Resident Care and Support Services
Continence Care
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Bathing

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that a resident was offered at minimum two baths per week by the method of their choice.

Rationale and Summary

A resident's plan of care documented that the resident was to have two baths per week on specified days.

In approximately a six-week period, the resident missed four of their baths. A Personal Support Worker (PSW) said they did not provide the resident with two baths as scheduled.

The home's Continence Lead/PSW Education Coordinator and an Assistant Director of Care (ADOC) said staff were to offer baths or showers twice a week and inform them if the bath schedule needed adjustments.

By not ensuring that a resident was bathed according to their plan of care, increased the risks associated with not meeting the resident's hygiene requirements.

Sources: a resident's clinical records and interviews with a PSW, the Continence Lead/PSW Education Coordinator and an ADOC. [758]

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) (i)
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,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee has failed to ensure that a resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, when the resident had an area of skin issue.

Rationale and Summary

A PSW documented that a resident had a new skin issue.

A Registered Practical Nurse (RPN) said that when a resident was identified to have

a new skin issue, registered staff would be expected to complete an assessment.

The initial Skin Assessment was not completed until two days after the skin issue was noted. The following day, the resident had a change in their condition.

The home's failure to complete a skin assessment when the skin issue was first noted, could have prevented early identification and treatment of any potential concerns.

Sources: a resident's clinical records, and interviews with staff. [000690]

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

The licensee has failed to ensure that a resident who was incontinent, received an assessment using a clinically appropriate assessment instrument specifically designed for assessment of incontinence that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific

interventions.

Rationale and Summary

A resident was incontinent since their admission to the home and used a specific continence product for their care.

The home's Continence Management policy documented that a continence assessment using the Continence Assessment tool was to be completed on admission and with any change in a resident's condition affecting bladder and bowel continence. A Three-Day Elimination Monitoring Record was to be initiated 72 hours after the resident's admission and analyzed when completing the continence assessment.

Upon the resident's admission to the home, a continence assessment was not completed according to the home's policy.

Approximately one year later, the resident had a change in their incontinence, and asked for an additional continence care product.

There were no assessments completed to indicate the change in the resident's continence status and the use of different continence care products. The resident's written plan of care was also not updated.

An RPN and an ADOC said when a resident had a change in their continence status, they should be re-assessed and their plan of care updated to reflect these changes, including the change in the continence product used.

Gaps in the assessment of the resident's continence status and their continence products increased the risk that staff were not aware of changes in the resident's continence and appropriate interventions could not be developed and implemented to manage these changes.

Sources: a resident's clinical records, resident worksheet for continence care products, the home's Continence Management Program policy and interviews with a resident and staff. [758]

WRITTEN NOTIFICATION: Pain management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.
Pain management
s. 57 (1) The pain management program must, at a minimum, provide for the following:
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

The licensee has failed to comply with their pain management policy for a resident.

In accordance with O. Reg 246/22 s.11. (1) b, the licensee is required to ensure that monitoring of residents' responses to, and the effectiveness of, the pain management strategies, is complied with.

Rationale and Summary

The home's pain identification and management policy stated that Registered Staff were to assess the effectiveness of pain control strategies pre and post intervention and determine if the effect of the intervention meets the resident's goal for pain management or if a pain intervention requires adjustment.

A resident had pain and as per need (prn) medication was given, but it was not

documented in the resident's Medication Administration Record (MAR).

The Director of Care (DOC) confirmed that the prn medication was not documented on the MAR and therefore the effectiveness of the prn medication was not assessed to determine if the resident's pain was relieved.

The home's failure to assess that the effectiveness of the prn medication may have led to the resident being in pain for an extended period of time.

Sources: a resident's clinical records, the home's Pain Identification and Management Policy, and an Interview with the DOC. [000690]

WRITTEN NOTIFICATION: Housekeeping

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee has failed to ensure that cleaning and disinfection was implemented in accordance with the manufacturer's specifications for a resident care equipment.

Rationale and Summary

The manufacturer's specifications for the use of a shared resident care equipment stated that it should be cleaned and disinfected before the first use and after each patient use.

On one occasion, a shared resident care equipment in one of the Resident Home Areas (RHA) was observed to have an empty container of disinfectant attached to it.

The PSW Education Coordinator confirmed the disinfectant bottle to the equipment was empty and that the equipment was used without being cleaned and disinfected.

Failure to follow the manufacturer's instructions for cleaning and disinfecting shared resident equipment increased risks of potential transmission of micro-organisms to residents and staff.

Sources: an observation, the manufacturer's instructions for a shared resident care equipment, and interviews with staff [706119]

WRITTEN NOTIFICATION: Dealing with Complaints

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)
Dealing with complaints
s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;

(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The licensee has failed to ensure that a documented record of the written complaint alleging neglect and care concerns of a resident was kept in the home.

Rationale and Summary

The home received a written complaint alleging neglect of a resident and multiple care concerns. The complaint could not be resolved within 24 hours.

The home's complaints and customer service policy documented that a complaint investigation form should be completed if the complaint cannot be resolved within 24 hours. The complaint form should include the date and the nature of the complaint, a summary of the investigation, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

The home's Executive Director (ED) and an ADOC said a complaint record was not completed for the above complaint.

By not keeping a record of the complaint, the complaint may not be reviewed and

analyzed for trends and to develop improvements to the home's processes.

Sources: a critical incident report, the home investigation records, the home's Complaints and Customer Service policy and interviews with an ADOC and the ED. [758]

WRITTEN NOTIFICATION: Medication Management System

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure that the written protocol for processing new medication orders was implemented for a resident.

Rationale and Summary

In accordance with O. Reg. 246/22, s. 123 (1) and in reference to s. 123 (2), the licensee was required to develop written policies and protocols for the medication management system to ensure the accurate administration of all drugs used in the home.

The pharmacy provider's policy regarding new medication orders documented that nurses would sign and date the first nurse check after obtaining informed consent from the resident or their Substitute Decision Maker (SDM) and flag the order until the second nursing check was completed. The resident and/or their SDM should be

informed of all new medication orders.

i) A new medication was prescribed for a resident. The resident was not able to make decisions about their care and treatment and their SDM was to be informed prior to starting any treatment.

Two registered staff did not follow the pharmacy's provider policy when they processed the new medication order without obtaining consent from the resident's SDM.

The resident received five doses of the new medication without their SDM being informed.

An ADOC said staff should have obtained consent from the resident's SDM when completing the first and second nurse check and followed up with the resident's SDM after leaving a voice mail.

ii) A new medication was prescribed to a resident, and it was not consented by their SDM.

An RN said they did not obtain consent from the resident's SDM when they processed the new medication order and were unaware that the consent was refused.

One day later the resident received one dose of the new medication.

An RPN said they administered the new medication without following the policy for processing the new medication orders and left a voice mail to inform the resident's SDM.

Staff not following the procedure for processing new medication orders and obtaining informed consent from the resident's SDM resulted in administration of treatments for which consent had not been obtained.

Sources: a resident's clinical records, the home's pharmacy provider's policy and interviews with staff [758]

WRITTEN NOTIFICATION: Residents' Drug Regimes

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 146 (a)
Residents' drug regimes
s. 146. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

The licensee has failed to ensure that when a resident was administered a psychotropic drug, there was monitoring in place and documentation of the resident's response and the effectiveness of the drug.

Rationale and Summary

A psychotropic medication was prescribed for a resident to manage their responsive behaviours.

The home's responsive behaviours policy documented that when initiating

pharmacological interventions related to behaviours staff were to document in progress notes the resident's response to the medication daily for the first two weeks or as ordered by the physician to assess effectiveness.

A resident received five of doses of a psychotropic medication and subsequently, they were noted with adverse reactions.

There was no monitoring in place or any documentation of the resident's response to and the effectiveness of the medication, except for one occasion when the resident refused all their medications.

By not monitoring the resident when they were administered a psychotropic medication increased the risk that the first signs of the medication side effects were not identified, and appropriate actions may not have been implemented in a timely manner.

Sources: a resident's clinical records, the home's Responsive Behaviours policy, and interviews with staff. [758]

WRITTEN NOTIFICATION: Medication Incidents and Adverse Drug Reactions

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (2) (c)
Medication incidents and adverse drug reactions
s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 66/23, s. 30.

The licensee has failed to ensure that a written record to include the revision, analysis and corrective actions taken in relation to a resident's adverse drug reaction was kept in the home.

Rationale and Summary

A resident had an adverse reaction to a new medication.

An RN and an ADOC said a medication incident was not submitted regarding the resident's adverse reaction to the medication.

By not keeping a record of the medication incident related to an adverse drug reaction, the incident was not reviewed and analyzed, and corrective actions to prevent recurrence implemented in a timely manner.

Sources: a resident's clinical records, the pharmacy provider's Medication Incident reporting and Adverse drug Reactions and Drug allergies policies and interviews with staff. [758]

WRITTEN NOTIFICATION: Hiring staff, accepting volunteers

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 252 (2) (b)
Hiring staff, accepting volunteers
s. 252 (2) The police record check must be,
(b) conducted within six months before the staff member is hired or the volunteer is accepted by the licensee.

The licensee has failed to ensure that an agency RPN had a police record check within six months of date of hire.

Rationale and Summary

An agency RPN's police record check was completed approximately one year prior to the date of their employment at the home.

By failing to ensure that an agency RPN's police record check had been completed within six months of hire there was a potential risk to residents as not verifying this could lead to hiring of an individual with documented criminal behavior towards vulnerable individuals.

Sources: Interview with the DOC, police record check and employee file for an agency RPN [706119]

WRITTEN NOTIFICATION: Exceptions

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 254 (4)
Exceptions
s. 254 (4) If a staff member is hired or a volunteer is accepted during a pandemic and no police record check that complies with subsections 252 (2) and (3) was provided to the licensee, the licensee shall ensure that a such police record check is provided to the licensee within three months after the staff member was hired or the volunteer was accepted, and the licensee shall keep the results of the record check in accordance with the requirements in section 278 or 279 as applicable.

The licensee has failed to ensure that during a pandemic two agency RNs had a police record check submitted to the home within three months after being hired.

Rationale and Summary

A) An agency RN had their police record check on file dated more than six months prior to their date of hire.

B) An agency RN had no police record check with a vulnerable screen on their file.

The home's failure to ensure that two Agency RN's police record check during a pandemic had been submitted to the home within three months after hire was a potential risk to residents as not verifying this could lead to hiring of an individual with documented criminal behavior towards vulnerable individuals.

Sources: Interview with ED, DOC, staff employee file and police record check for two agency RNs [706119]

COMPLIANCE ORDER CO #001 Continence care and bowel management

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (f)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall ensure that:

1) Residents requiring the use of a specific type of continence care product are assessed and provided continence products based on their individual assessed needs as outlined in the regulations, including the specified continence product and these assessments are to be documented.

2) Residents who currently use their own supply of the specific continence care product are aware that a range of continence care products, including the specific continence product is available to them at no cost and this communication is documented and included in the resident's plan of care.

3) An audit is conducted of all residents that have lived in the home within the identified period of time, to determine if they had used or are using the specified continence care product.

(i) If this product was or is used, the home will determine when the product was provided by the home, when the resident/representative was providing the product, and if the product was or is an assessed need.

(ii) When the product was provided by the resident/representative the licensee will reimburse all actual or estimated expenses incurred by the resident/representative, for the full cost of the products used.

4) A copy of the audit and all supporting documentation is kept in the home, including the list of residents who wear the specified continence care product,

when they started wearing them, whether they were reimbursed, rationale if they were not, and how much was the reimbursement.

Grounds

The licensee failed to ensure that a range of continence care products was available and accessible to residents and staff at all times.

Rationale and Summary

A complaint was received by the Ministry of Long-Term Care regarding the availability of a specific type of continence care product and restrictions in accessing the product by residents and staff.

The home placed their last order for the specific type of continence care product approximately eight months ago.

Multiple staff members, including the home's Continence Lead/PSW Education Coordinator and an ADOC said the home announced that the specified continence care product would no longer be provided for the residents. The residents were to be provided with a comparable continence care product. The residents and their families were directed to purchase their own supplies if they wanted to continue using the specified continence care product.

i) A resident was incontinent and required a continence care product for their continence needs.

The resident said the home was supplying them with a specific continence care product upon their admission to the home. Subsequently, they were told that the home no longer provided these products because they were too expensive, and

they had to purchase their own supply. Alternatively, they could use a comparable continence care product.

The resident and multiple staff acknowledged that the continence care products provided to this resident were difficult to use and did not meet the resident's needs.

The home's Continence Lead/PSW Education Coordinator acknowledged that the easiness of use, comfort, and promoting independence were not considered when the comparable continence care products were offered to the resident.

An ADOC said when the home no longer provided the specific continence care product, the resident was not assessed and provided with continence care products based on the resident's continence care needs.

ii) A resident was assessed to be appropriate for a specific type of continence product. Their care plan documented that their family provided this product for the resident.

After inspector #758's discussion with the home, the home provided a list of multiple residents, including the two identified residents, who were purchasing the specific type of continence care product for themselves, despite being assessed as appropriate to wear them.

By restricting residents and staff access to a specific type of continence care product, multiple residents had to purchase their own supply, which impacted them financially.

Sources: observation of the home's supplies of continence care products, observation of a resident's continence care products supply, the home's Resident

Worksheet for continence care products (January 17, 2024), Resident Worksheet for continence care products for all RHAs (February 23, 2023), Decision tree for the specific type of continence care product records, two residents' clinical records, and interviews with a resident, PSWs, an RPN, the home's Continence Lead/PSW Education Coordinator, an ADOC, and the ED. [758]

This order must be complied with by April 22, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor

Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.