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

**Ottawa District**
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

# Original Public Report

**Report Issue Date:** August 17, 2023

**Inspection Number:** 2023-1035-0002

**Inspection Type:**
Complaint
Critical Incident System

**Licensee:** CVH (No. 6) 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 Cornwall, Cornwall

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Ashley Bernard-Demers (740787) | Ashley F Bernard -Demers Digitally signed by Ashley F Bernard-Demers Date: 2023.08.18 11:00:34 -04'00' |

**Additional Inspector(s)**
Darlene Murphy (103)
Anna Earle (740789)

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 31, 2023 and August 1-4, 2023

The following intake(s) were inspected:
Intake: #00090846 - Complaint regarding pain management and alleged emotional abuse
Intake: #00089071 - Complaint regarding medication administration and resident care
Intake: #00092325 - CIR #3063-000014-23 - Fall of resident resulting in injury
Intake: #00092499 - Complaint regarding resident care and falls
Intakes : #00092567, #00093525, and Intake #00092371, CIR #3063-000015-23 - Complaints regarding alleged resident neglect and abuse
Intake: #00092638 - CIR #3063-000016-23 - Alleged sexual abuse of resident

The following intakes were completed in this inspection: Intake #00015333, CIR #1131-000027-22; Intake #00088689, CIR #3063-000006-23 were related to falls.

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

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

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Residents' Bill of Rights

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 3 (1) 17.

The licensee failed to ensure that staff were wearing identification.

**Rationale and Summary**
Inspectors #740787 and #103 observed staff members not wearing name tags.

In an interview the Executive Director stated that the expectation is all staff wear their name tag, inclusive of agency staff.

Staff not wearing identification impacts the residents the right to know who is providing their care.

**Sources:** Observations of staff members, and an interview with the Executive Director

[740787]

## WRITTEN NOTIFICATION: Plan of care

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that the care provided to residents was as specified in their plans of care.

**Rationale and Summary**
A resident was observed to be asleep in their bed, and the required falls prevention equipment was not in use for the resident.

The resident's fall prevention interventions in their plan of care indicated that the intervention is to be in use when the resident is in bed.

The impact of not using the specified intervention for the resident places them at risk for falls.

A resident's transfer plan of care indicated their required transfer status. The resident's head of bed signage indicated their required transfer status as well.
It was observed that the resident was not transferred as specified in the plan of care.

The impact of not transferring the resident as per their plan of care places the resident at risk for injury.

**Sources:** Observation of residents, the signage at their head of bed, and review of clinical records

[740787]

## WRITTEN NOTIFICATION: Training

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 82 (2)

The licensee failed to ensure that a staff member completed the required orientation education prior to performing their responsibilities.

**Rationale and Summary**
An education report was reviewed for all staff hired from June 1, 2023, onward. It was identified that a staff member had not completed any required courses prior to performing their responsibilities.

The Human Resources Coordinator confirmed that the staff member had not completed their mandatory education prior to working on the home areas with residents.

The impact of staff not completing their orientation training, prior to performing their responsibilities places the residents at risk.

**Sources:** Review of an education report and interview with the Human Resources Coordinator

[740787]

## WRITTEN NOTIFICATION: Care conference

**NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 30 (1) (a)

The licensee failed to conduct an interdisciplinary care conference which provided the opportunity for discussion between team members, residents, and their chosen attendees.

**Rationale and Summary**
A resident's Interdisciplinary Team Care Conference was documented to be have been completed on a day in May 2023. The section available to list all participants included one name. There was a section identifying Power of Attorney (POA) concerns; however, there is no evidence that the opportunity for the POA to have a discussion with the interdisciplinary team occurred.

The Director of Care stated the care conference process, based on the volume of the initial admissions, was for nursing to call the families, and if concerns were identified nursing would forward the concerns to the appropriate department manager for follow-up. The Director of Care confirmed that the families weren't coming into the home for the care conferences.

The impact of not providing residents and families the ability to have a discussion with the interdisciplinary team places residents at risk to not have their concerns, or the concerns of their chosen participants addressed in a collaborative manner.

**Sources:** Review of resident clinical records and interview with the Executive Director and Director of Care

[740787]

## WRITTEN NOTIFICATION: Nutritional care and hydration programs

**NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)

The licensee failed to ensure that weights were obtained monthly.

**Rationale and Summary**
A review of health records for three residents indicated that weights were not obtained monthly.

The Height and Weight Monitoring Policy stated that all residents will be weighed on admission and monitored at least once a month thereafter and whenever a significant change occurs that can affect the resident's weight.

A staff member indicated that residents are to be weighed monthly.

The Registered Dietitian indicated that residents are to be weighed monthly by the nursing department.

The impact of not obtaining monthly weights places residents at risk for weight changes that are not identified and addressed.

**Sources:** Resident's clinical records, Height and Weight Monitoring Policy, interviews with staff members

[740787]

## WRITTEN NOTIFICATION: Infection prevention and control program

**NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that Infection Prevention and Control practices were followed in the home.

**Rationale and Summary**
A home area was experiencing an outbreak at the time of inspection.

A staff member was observed on the home area in outbreak to not be wearing a mask, as well, another staff member was observed to be donning their mask around their chin, exposing their mouth and nose.

Inspector #103 observed a staff member on the home area in outbreak to have their mask over their mouth, but below the nose.

A staff member indicated that surgical masks were to be worn while on the outbreak home area. The Executive Director indicated that the masking expectation for staff on the outbreak home area, not presently caring for symptomatic residents, was a surgical mask.

The impact of not following the home's direction for masking on a unit in outbreak places residents at risk of infection.

**Sources:** Observations made on a resident home area, interviews with staff and the Executive Director

[740787]

## WRITTEN NOTIFICATION: Reporting and Complaints

**NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 108 (2)

The licensee failed to ensure that a documented record of complaint was kept in the home.

**Rationale and Summary**
Review of the Licensee's "Complaint Manual" binder indicated the home is to maintain a record of all complaints and actions taken in the "Complaint Log".

A complaint was lodged with the Licensee on a day in July 2023, and no documented record of complaint was evident in the home.

Review of the home's complaint portal and complaint manual binder did not contain the complaint that was lodged on a day in July 2023.

During an interview with the Director of Care and Executive Director, it was confirmed the lodged complaint was not documented in their record of complaints.

Failure to maintain written documentation of complaints risks the lack of monitoring of trends, proper resolutions and ensuring residents maintain their quality of life.

**Sources:** Review of Complaint Manual Binder, Complaint Portal, and interview with Director of Care and Executive Director

[740789]

## WRITTEN NOTIFICATION: Administration of drugs

**NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that medications were administered in accordance with directions for use specified by the prescriber.

**Rationale and Summary**
A staff member stated that a resident did not receive a course of medication, and indicated they became aware of this as they found the medications in the medication cart drawer, still in the packaging.

A medication incident report was completed for this resident indicating missed medication administrations.

A staff member stated that residents did not receive their noon medications on a day in April 2023.

Upon review of the electronic medication administration records (eMAR), it was identified there were missed noon hour medications for residents on a day in April 2023.

The Executive Director confirmed that residents did not receive their scheduled noon medications on a day in April 2023.

**Sources:** Medication incident report, review of clinical records of residents, and interviews with a staff member and the Executive Director

[740787]

## 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 (1) (a)

The licensee has failed to ensure that there was a documented record of medication incidents.

**Rationale and Summary**
A staff member informed Inspector #740787 that residents did not receive their noon medications on a day in April 2023.

Upon review of the electronic medication administration records (eMAR) for residents it was noted that on a day in April 2023 resident's noon hour medications had not been signed off as administered.

In an interview with the Executive Director, they stated there were "about eight" residents that missed their noon medication on a day in April 2023. The Executive Director was unable to provide documented medication incident reports for these medication incidents and indicated that they were not done.

The impact of not documenting medication incident reports places the residents at risk as there was no evaluation of the situation to mitigate recurrence.

**Sources:** Interviews with staff members and the Executive Director, and review of clinical records of residents

[740787]

## WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

**NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)

The licensee failed to inform residents substitute decision makers of medication incidents.

**Rationale and Summary**
A staff member informed Inspector #740787 that residents did not receive their noon medications on a day in April 2023.

Upon review of the electronic medication administration record (eMAR) for residents it was noted that noon hour medications had not been signed off as administered on a day in April 2023.

Upon follow-up with Inspector #740787 on the Executive Director stated there were "about eight" residents that missed their noon medication on a day in April 2023.

The Executive Director confirmed that the Power of Attorneys (POAs) were not informed upon the management becoming aware of these medication incidents.

The impact of not informing resident's Power of Attorney's (POAs) or substitute decision makers (SDMs) of medication incidents places the residents at risk as this limit the involvement of their support people of choice in their care.

**Sources:** Interviews with staff members, the Director of Care and Executive Director, and review of clinical records of residents

[740787]

## COMPLIANCE ORDER CO #001 Pain Management

**NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: O. Reg. 246/22, s. 57 (1) 4.

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

1) Complete a 72-hour pain assessment for the resident for day, evening and night shifts (when resident is awake) using a clinically appropriate pain assessment tool designed for this purpose.

2) Inform all direct care staff providing care for the resident, including but not limited to PSW, dietary staff, activity aides, housekeeping staff, physiotherapy staff, in writing of the need to report to the Registered Practical Nurse or Registered Nurse all pain reported by the resident or observed by staff members.

3) Ensure the physician and/or nurse practitioner review the outcome of the pain assessment upon completion.

4) In accordance with the home's pain policy, if medication changes are made based on the outcome of the 72-hour pain assessment, complete an additional 72-hour pain assessment for the resident for day, evening and night shifts (when resident awake). As applicable, ensure the outcome of the 72-hour pain assessment is reviewed by the physician and/or nurse practitioner upon completion.

5) The Director of Care (or designate) shall complete daily audits on the resident medication administration record from the start of the 72-hour pain assessment up to and including 5 days following the completion of the assessment to ensure compliance with the pain management policy.

6) Document when the audits were completed, the details of the audits and any actions taken as a result of the audits.

7) Ensure all registered staff working on the resident's home area during the period of the 72-hour pain

assessment(s) and the 5 days following the completion of the assessment(s) review and attest by signature their review of the home's pain management policy.

8) Keep a record of all registered staff that worked during the period of the 72-hour pain assessment(s) and their written attestation of having completed the review of the pain management policy.

**Grounds**
Non-compliance with O. Reg 246/22, s. 57 (1) 4
The licensee has failed to comply with their pain policy.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to have policies as a part of their pain management program that includes the assessment/reassessment of resident pain, and that the policy is complied with.

Specifically, the home failed to comply with "Pain Management" dated March 2023 for failing to complete a pain assessment for 72-hours on day, evening and night shifts (when resident awake) when a new pain medication was started for the resident. Additionally, the home failed to assess the resident's pain when breakthrough medication was used on three consecutive days and failed to notify the physician or nurse practitioner of the frequency of use of the breakthrough medication.

**Rationale and Summary**
A pain assessment for the resident was completed that indicated the resident had constant, aching pain and the pain was rated as a 7/10. The Nurse Practitioner (NP) prescribed a breakthrough medication for the resident after being advised the resident was reporting constant pain despite the current analgesic regime. The resident health care record was reviewed and there was no documented evidence to support the completion of a 72-hour pain assessment following the initiation of this new pain medication.

On three consecutive days, the resident received the breakthrough medication for pain. A documented pain assessment was not completed as per the policy and neither the nurse practitioner nor the physician was notified of the resident's requirement for the breakthrough medication. In addition, the resident was noted to have received breakthrough medication on three consecutive shifts and there was no documented pain assessment or communication of this increased use in breakthrough medication to the physician or the nurse practitioner.

Failure to assess/reassess this resident's pain in accordance with the pain policy, placed this resident at risk by compromising their quality of life.

**Sources:** "Pain Management" policy, review of the resident health care record, interviews with the resident, Personal Support Workers (PSW), an Activity Aide (AA), Physiotherapy assistant (PTA), Registered Practical Nurse and Nurse Practitioner (NP).

[103]

**This order must be complied with by** August 30, 2023

## 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.