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
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Original Public Report

Report Issue Date: December 12, 2023
Inspection Number: 2023-1035-0004
Inspection Type: Complaint Critical Incident Follow up
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
Lisa Cummings (756)	Lisa Cummings Digitally signed by Lisa Cummings Date: 2023.12.14 14:06:20 -05'00'

Additional Inspector(s) Megan MacPhail (551) Jessica Lapensee (133)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 17, 18, 19, 23, 25, 26, 27, 30, 31, 2023 and November 1, 2023
The inspection occurred offsite on the following date(s): November 24, 2023

The following intake(s) were inspected:

- Intake #00088141: A complaint with concerns regarding staffing, bathing and communication with residents.
- Intake #00088268: A complaint with concerns regarding bathing and staffing of dietary aides.

- Intake #00089678: A complaint with concerns regarding maintenance schedules, air conditioning system, doors of the home, and air temperatures.
- Intake #00089894: A complaint with concerns regarding response times for personal care, bathing, missing clothing, staffing, and the pest control program.
- Intake #00090017: A complaint with concerns regarding food and nutrition, staffing and timing of personal care.
- Intake #00091647: A complaint with concerns regarding the television system in resident rooms, the recreation program and availability of automatic doors in the home.
- Intake: #00092514: A complaint with concerns regarding staffing, food and nutrition and dietary services.
- Intake #00092826: A complaint regarding water temperature.
- Intake #00094836: Follow-up of compliance order #001 from inspection #2023-1035-0002
- Intake #00096416, (CI #3063-000040-23): Failure / breakdown of the resident-staff communication and response system.
- Intake #00098559: A complaint with concerns regarding weight loss and food texture. Additional concerns from this complaint intake were reassigned for inspection.

NOTE: Related to intake #00089678, a Written Notification related to FLTCA, 2021, s. 19 (2) (c), a Written Notification related to O Reg. 246 / 22, s. 24 (1), and a Compliance Order related to FLTCA, 2021, s. 82 (2) 10 were identified during this inspection and have been issued in concurrent inspection #2023-1035-0003, dated December 12, 2023.

Related to intakes #00092514, #00088141, and #00088268, a Written Notification related to O. Reg. 246 / 22, s. 6 (9) 1. was identified in this inspection

and has been issued in concurrent inspection #2023-1035-0003, dated December 12, 2023.

Related to intake #00091647, Written Notifications related to O. Reg. 246/22, s. 77 (5) and s. 78 (2) (f) were identified in this inspection and have been issued in concurrent inspection #2023-1035-0003, dated December 12, 2023.

Related to intake #00090017, a Written Notification related to O. Reg. 246/22, s. 78 (2) (d) was identified in this inspection and has been issued in concurrent inspection #2023-1035-0003, dated December 12, 2023.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2023-1035-0002 related to O. Reg. 246/22, s. 57 (1) 4. inspected by Megan MacPhail (551)

The following Inspection Protocols were used during this inspection:

Housekeeping, Laundry and Maintenance Services
Safe and Secure Home
Infection Prevention and Control
Pain Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Administration of Drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246 / 22, s. 140 (2).

The licensee has failed to ensure that a medication was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
On one day, the resident was ordered a medication twice daily, for which they were already receiving the morning dose. The Director of Care (DOC) stated that the first evening dose of the medication was only administered starting the following day.

On another day, the resident's evening dose of the same medication was increased. The increased dose was not administered on that day as prescribed.

By not administering the medication as prescribed, the resident was at risk of experiencing undue pain.

Sources: Resident health care record and interview with DOC.

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WRITTEN NOTIFICATION: Emergency Plans

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 268 (4) 1. ix.
Emergency plans
s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with emergencies, including, without being limited to,
ix. loss of one or more essential services,

The licensee has failed to comply with the emergency plan that provides for dealing with loss of the resident-staff communication and response system (RSCRS).

Rationale and Summary
In accordance with O. Reg. 246 / 22, s. 11 (1)(b), the licensee is required to ensure there is an emergency plan that provides for dealing with the loss of one or more essential services.

In accordance with O. Reg. 246 / 22, s. 22 (1)(c), the RSCRS is defined as an essential service.

Staff did not comply with the emergency plan titled "Code Grey – Essential Services" which provides for dealing with the loss of the RSCRS. As per the plan, direct care staff are to complete and document resident checks every 15 minutes when the nurse call bell system is not working using the 24hr resident check log.

The RSCRS was disrupted in that the momentum cell phones that were to be carried by care staff in order to receive calls for assistance from the residents were disconnecting from the Wi-Fi server. Care staff were therefore not receiving calls

from residents on their phones. The issue appeared to be resolved when the DOC left the building however the disruption reoccurred throughout the night shift. By the following day, all of the momentum cell phones were receiving calls from residents once again. The DOC indicated that during the service disruption, residents were checked on every 15 minutes however these checks were not documented.

Sources: Review of the code grey emergency plan, review of a critical incident report submitted to the Director detailing the malfunction of the resident-staff communication and response system, interview with the Director of Care.

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