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: November 14, 2024
Inspection Number: 2024-1035-0007
Inspection Type: Complaint Critical Incident
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 24, 25, 28, 30 and 31, 2024, November 1, 4, 5, 6 and 7, 2024

The following intake(s) were inspected:

- Intake: #00124596 - Complainant with concerns about a resident's care.
- Intake: #00125787 - Complainant with concerns about a resident's elopement.
- Intake: #00126878 - related to an unexpected death of a resident.
- Intake: #00127991 and intake: #00128804 - related to a resident's falls resulting in a significant change in the resident's condition.
- Intake: #00128116 - related to alleged improper/incompetent treatment of a resident by staff.

The following Inspection Protocols were used during this inspection:

Food, Nutrition and Hydration
Infection Prevention and Control

Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty of licensee to comply with plan

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in a resident's plan of care was provided as specified when a Personal Support Worker (PSW) provided the wrong dietary requirement to the resident that resulted in a change in the resident's health condition.

Sources: Resident's care plan, Registered Dietitian's progress notes, Registered Nurse's progress notes, interview with the PSW and Director of Care (DOC).

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed. Specifically, the licensee has failed to complete a specific assessment and monitor as recommended and confirmed by two registered staff members.

Sources: resident's record review, interviews with two Registered Nurses (RN) and the DOC.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a

risk of harm to the resident.

The licensee has failed to ensure that the improper care of a resident that resulted in harm was immediately reported to the director when a Personal Support Worker (PSW) provided the wrong dietary requirement to a resident that resulted in a change in the resident's health condition.

Sources: Critical incident report, interview with the DOC.

WRITTEN NOTIFICATION: Responsive behaviours

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that the strategies that were developed, to respond to a resident's demonstrated responsive behaviours, were implemented. Specifically, the licensee has failed to ensure that the strategies developed by the Behaviour Support Ontario PSW for managing the resident's responsive behaviours, were implemented.

Sources: resident's electronic health record and paper chart, Interviews with two RNs and DOC.

COMPLIANCE ORDER CO # Plan of care

NC # Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

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

A) Conduct audits on the Plan of Care for all the residents, who require catheters, to ensure that the care to be provided to the residents is specified in the residents' written plan of care and includes clear directions on the type and size of catheter to be used for all identified residents. Take corrective actions if any deviations from the plans of care are identified.

B) Keep written records of everything required under step A and B. Written records must be kept until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds
The licensee has failed to ensure that the written plan of care for a resident set out clear directions to the staff who provided direct continence care to the resident. Specifically, the licensee has failed to ensure that clear directions, in the use of a medical device, were provided to staff when the resident was identified with having

a health ailment.

The resident's written plan of care identified that the resident had a specific ailment. The resident's Medication Reconciliation Form noted that the resident had this ailment. The resident's Medical Directives included an order for a medical device, the resident's Prescriber Order Form contained orders to change the resident's medical device but did not contain any specification, as to accommodate their ailment. In a review of the resident's Medication Administration Records (MAR) and Treatment Administration Records (TAR), the inspector noted no orders were indicated to support the resident's ailment were transcribed on the MAR or TAR.

In a progress note, it was documented that upon assessment the resident had a significant change in health status. A physician order was received for the resident to start a medication, to change the device and provide a test. The nurse documented that the device which was removed had not supported the resident's specific ailment.

Sources: resident's electronic and paper health record.

This order must be complied with by January 24, 2025

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REVIEW / APPEAL INFORMATION

TAKE NOTICEThe 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.