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

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Public Report

Report Issue Date: January 10, 2025
Inspection Number: 2025-1109-0001
Inspection Type: Critical Incident
Licensee: Southampton Care Centre Inc.
Long Term Care Home and City: Southampton Care Centre, Southampton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 7-10, 2025

The following intake(s) were inspected:

- Intake: #00130911 -allegation of incompetent care of a resident

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)
Plan of care
s. 6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The licensee failed to ensure a resident's Power of Attorney (POA) was given an opportunity to participate fully in the development and implementation of their plan of care when concerns and wishes were not responded to by the home.

Sources: resident clinical record, email, interview with staff

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 failed to update and revise a resident's care plan when they experienced a change of condition. Staff at the home confirmed the resident's care plan had not been updated.

Sources: resident clinical record, interviews with staff

WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)
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,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

The licensee failed to ensure a resident received immediate treatment and interventions to promote wound healing and prevent infection.

Sources: review of a resident's clinical record, interview with staff

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 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. O. Reg. 246/22, s. 102 (2).

The license failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control were implemented.

In accordance with additional requirement 7.3 (b) under the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (April 2022, revised September 2023) audits were to be completed at a minimum of quarterly of all staff to ensure that they can perform the IPAC skills required of their role. Audits provided did not include staff in all departments.

Sources: IPAC audits, interview with staff

WRITTEN NOTIFICATION: Administration of drugs

NC #005 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 failed to ensure a resident's medication was administered as prescribed.

The resident's clinical record documented they were experiencing pain and discomfort on numerous occasions. No as needed medication was administered.

Sources: a resident's clinical record and interview with staff