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
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Original Public Report

Report Issue Date: February 21, 2023
Inspection Number: 2023-1703-0001
Inspection Type: District Initiated
Licensee: CVH (No. 8) 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**
Katy Harrison (766)	Kathryn Harrison Digitally signed by Kathryn Harrison Date: 2023.02.22 11:34:09 -05'00'

Additional Inspector(s)
Gabriella Del Principe (741734)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 7-9, 14,15, 2023

The following intake(s) were inspected:

- Intake: #00019967 - District Initiated Inspection (Modified) related to staffing
- Intake #00019870 - Complaint related to resident care

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

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee failed to ensure that documentation of care for residents #001 and #018 was completed.

Rationale and Summary
A review of residents #001 and #018 record demonstrated that documentation was missing to indicate that they received care as per their plan of care. In a report that focused on the last 14 day's documentation was missing three times for resident #001, and two times for resident #018.

In an interview with resident #001 and #018, they confirmed that they received care as scheduled.

An interview with the Director of Care (DOC) confirmed that the documentation of the care for residents #001 and #018 were not appropriately completed.

When the documentation for residents #001 and #018 care was not completed to reflect the care provided, it could have prevented the home from ensuring that the care needs for the residents were sufficiently met.

Sources: Record review of the 14-day look back bath report; interviews with residents #001 and #018; and interview with the DOC.

[741734]

WRITTEN NOTIFICATION: Assisting Residents with Eating

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 79 (2) (b)

The licensee has failed to ensure that residents who required assistance with eating or drinking were not served a meal until someone was available to provide the assistance required by the resident.

Rationale and Summary
Residents #003 and #004 were served their entree in the dining room, before a staff member was available to provide assistance. Resident #003 waited 13 minutes, and resident #004 waited six minutes, before staff members finished completing other meal service responsibilities and were available to assist them.

In an interview with Registered Practical Nurse (RPN) #108, it was confirmed that residents who require assistance should not be served their meal, until a staff member is available to provide assistance right away.

Failure to ensure that residents #003 and #004 were provided with assistance at the time of service could negatively impact their dining experience.

Sources: Observations in a dining room; and interview with RPN #108.

[741734]