Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: July 20, 2023.	
Inspection Number: 2023-1703-0002	
Inspection Type: District Initiated Complaint	
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 Katy Harrison (766)	**Inspector Digital Signature**
Additional Inspector(s) Sharon Perry (155) Dianne Tone (000686) Gabriella Del Principe (741734) Yami Salam (000688)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 20-23, 26-30, 2023

The following intake(s) were inspected:

- Intake: #00083984 - Complaint related to multiple care concerns.
- Intake: #00085749 - Complaint related to skin and wound management.
- Intake: #00086235 - Complaint related to visitation
- Intake: #00089510 - Complaint related to multiple care concerns.
- Intake: #00090186 - Post-Occupancy Inspection

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

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Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Medication Management
Safe and Secure Home
Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 12 (1) 1. i.

Rationale and Summary

It was observed that the gate leading from the first-floor fenced patio area was not locked.

The Environmental Services Manager (ESM) confirmed that the gate opens to outside the permitted area and noted that there was a screw missing allowing the gate to be opened from the inside and outside. They immediately contacted the company who was responsible for the maintenance of the doors to inform them that the gate required prompt attention.

To ensure resident safety, the ESM locked the door to the patio, preventing access for residents. There were no residents on the outdoor patio at the time. The ESM stated they would inform the charge nurse of the issue.

The gate was secured and repaired immediately, this was confirmed by the ESM, the gate was observed to be locked.

Failing to ensure that the gate was locked placed residents at low risk as the gate was closed and there were no residents on the patio at the time.

Sources: Observations of the gate leading to and from the fenced patio area; interview with Environmental Services Manager (ESM). [766].

Date Remedy Implemented: June 21, 2023.

WRITTEN NOTIFICATION: Plan of Care

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

The licensee failed to ensure that there was a written plan of care for two residents that set out the planned care for the resident, the goals the care was intended to achieve, clear directions to staff and others who provide direct care to the resident, and any other requirements provided for in the regulations. In accordance with O.Reg 246/22, s.29. (3) the plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to heat related illness, including protective measures required to prevent or mitigate heat related illness.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutritional care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.

16. Activity patterns and pursuits.
17. Drugs and treatments.
17.1 Medication reconciliation.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.

Rationale and Summary

A) A review of a resident's care plan demonstrated that several aspects of care, including related goals and interventions, were not included in the resident's plan of care.

A Registered Practical Nurse (RPN) and the Director of Care (DOC) confirmed that the care plan was not completed.

Failing to ensure that the resident's plan of care was fully completed placed the resident at moderate risk, as clear directions for all aspects of care were not identified or documented.

Sources: Resident clinical health records (electronic copy); interview with Director of Care (DOC). [766]

B) A review of another resident's care plan demonstrated that several aspects of care, including related goals and interventions, were not included in the resident's plan of care.

A PSW and the DOC confirmed that the care plan did not provide clear direction and was not completed.

Failing to ensure that the resident's plan of care was fully completed placed the resident at moderate risk, as clear directions for all aspects of care were not identified or documented.

Sources: Resident clinical health records; interview with Director of Care (DOC). [155]

WRITTEN NOTIFICATION: Duty of licensee to comply with plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in a resident's plan of care was provided as specified in the plan.

Rationale and Summary

A complaint was made to the Ministry of Long-Term Care (MLTC) with concerns regarding the resident's care.

The resident's medical record indicated that there was a physician's order that was not transcribed to the plan of care.

A Registered Nurse (RN) and Director of Care (DOC) stated that the physician's order was not transcribed and the resident's plan of care was not followed.

There was a moderate risk of harm to the resident when their plan of care was not followed.

Sources: Resident medical records, interviews with Registered Nurse (RN), Director of Care (DOC) [000688]

WRITTEN NOTIFICATION: Duty to Protect

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to protect two residents from neglect by the staff.

For the purpose of this Act and Regulation, "neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Rational and Summary

A) A resident stated that the wrist band, which is linked to the resident-staff communication and response system, does not work, they said they would press it, and nobody comes. The inspector asked the resident to press the wrist band at 1016 hours. The interview concluded at 1036 hours, no one had responded to the call. A PSW checked their phone and confirmed a call was made twenty-five minutes ago from the resident's room. The PSW said, the call was made but it didn't start beeping until they had

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logged into the program. An RPN opened their phone and stated, there are calls here, it didn't sound because the program was closed.

The Director of Life Enrichment (DLE) confirmed there had been issues related to staff logging into their phones, which enabled them to get the alerts, and stated, that's been the biggest issue.
Staff not responding to the resident-staff communication and response system places residents at risk for harm, as calls for assistance were not answered.

Sources: Observations of the resident-staff communication and response system; Interviews with Personal Support Worker (PSW), Registered Practical Nurse (RPN), Director of Life Enrichment (DLE). [766]

B) A resident expressed that the call bell on the wall did not work. They stated that once they go to bed in the evening they need to make sure that they have everything they need as they have rang the call bell and have gone all night without it being answered. They stated that they have no way to alert staff that they need assistance.

At 1146 hours the resident's call bell was activated. At 1248 hours, a PSW came to the resident to show them the lunch show plates. The PSW shared that they were the only PSW on the floor from 1130 until 1200 hours and that they were busy with three other residents that required care. The PSW was not carrying their phone and was unaware that the resident's call bell was activated.

Review of the call bell record for the resident showed:
-June 23, 2023 at 1923 hours the call bell was activated and rang for 9 hours and 4 minutes before being answered.
-June 27, 2023 at 1051 hours the call bell was activated and rang for 1 day and 11 minutes before being answered.
-June 29, 2023 at 1146 the call bell was activated and rang for 23 hours and 14 minutes before being answered.

The pattern of inaction and failure to answer the resident's call bell in a timely manner made the resident feel that their call bell did not work as staff did not respond. They felt that there was no way they could alert staff that assistance was needed once they were in bed. In addition, the PSW not carrying the phone when they were the only staff member on the floor put the residents at risk as they were unaware of anyone calling for assistance and would not have responded to the call bell.

Sources: Interviews with the Resident, Personal Support Worker (PSW), Director of Care (DOC), review of call bell records, resident clinical records, observations. [155]

WRITTEN NOTIFICATION: Air Temperature

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (5)

The licensee has failed to keep a documented record of the temperature measurements for at least one year.

Rationale and Summary

A complaint was made to the Ministry of Long-Term Care that a resident's room was overly warm. The Environmental Services Manager (ESM) stated that air temperatures of two rooms per wing were measured daily but they did not have a documentation of the recorded air temperatures for February and March 2023. Environmental Consultant stated that the temperature record system was not in place yet.

There was a risk that the resident's room was overly warm at the time of the reported concern. .

Sources: Interview with SDM, Resident, Environmental Services Manager, Environmental Consultant. [000688]

WRITTEN NOTIFICATION: Admission Assessments

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 28 (1) (a)

The licensee failed to ensure that all assessments to develop an initial plan of care for a resident were completed within 14 days of admission.

Rationale and Summary

A review of the resident's clinical health records demonstrated that several required assessments were not completed within 14 days of admission.

Failing to ensure that all required assessments were completed for the resident in the specified time frame delayed the resident from receiving the appropriate care to ensure safety and promote quality of

life.

Sources: Resident clinical health records (electronic and hard copy); interview with the Director of Care (DOC). [741734]

WRITTEN NOTIFICATION: Initial plan of care not fully completed/developed within 21 days of admission for resident #010.

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 28 (1) (b)

The licensee failed to ensure that an initial plan of care for a resident was developed within 21 days of admission.

Rationale and Summary

A review of the resident's records demonstrated that several aspects of care, including related goals and interventions, were not included in the resident's initial plan of care.

Failing to ensure that the resident's initial plan of care was fully completed in the specified time frame placed the resident at risk, as clear directions for all aspects of care were not identified or documented.

Sources: Resident clinical health records (electronic and hard copy); interview with Director of Care (DOC). [741734]

WRITTEN NOTIFICATION: Bathing

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)

The licensee failed to ensure that a resident was bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Rationale and Summary

The resident said that their bathing preference was a bath in the tub. They shared that they often did

not get a tub bath twice weekly as staff were too busy and did not have time or staff were unfamiliar with their care.

Review of the resident's records showed that the resident did not get a tub bath on nine separate occasion's.

The Director of Care (DOC) reviewed the resident's records and agreed that the resident did not get a tub bath at a minimum of twice weekly.

The resident not receiving a bath by the method of their choice at a minimum of twice weekly put them at an increased risk of health issues.

Sources: Resident clinical records, interviews with Resident and Director of Care (DOC). [155]

WRITTEN NOTIFICATION: Skin and Wound Assessment

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

The licensee of the Long-Term Care home failed to ensure that when a resident was exhibiting altered skin integrity, they received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary

A head-to-toe assessment was completed on admission of the resident that identified altered skin integrity. An assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment was not completed.

The Director of Care (DOC) said that an assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment was not completed until seven weeks after the area was first identified.

Failure to complete an initial skin and wound assessment using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment impacted the resident's health and quality of life when there was a delay in assessment resulting in the wound worsening.

Sources: Record review i.e., skin and wound assessment, documentation survey, jpeg photo, interview with a Registered Nurse (RN), Director of Care, (DOC).

WRITTEN NOTIFICATION: Skin and Wound Care

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (ii)

The licensee failed to ensure that treatment and interventions to promote healing for two resident's altered skin integrity were implemented.

Rationale and Summary

A) On the day of admission an area of altered skin integrity was identified.

A review of the resident's clinical health records demonstrated that following the skin assessment, there were no interventions initiated in the resident's plan of care related to wound care treatment and monitoring.

Failing to ensure that immediate interventions were initiated, prevented the resident from receiving immediate care to promote healing and placed the resident at risk for pain, discomfort, and infection.

Sources: Resident clinical health records (electronic and paper); interview with Registered Practical Nurse (RPN) and Director of Care (DOC). [741734]

B) A resident was admitted and on the day of admission they received a head-to-toe assessment from a registered staff member, and altered skin integrity was identified.

A review of the resident's clinical health records demonstrated that following the identification of the altered skin integrity, interventions were not initiated immediately.

Failing to ensure that immediate interventions were initiated, prevented the resident from receiving immediate treatment to promote healing and placed the resident at risk for worsening of wound and infection.

Sources: Record review i.e., skin and wound assessment, documentation survey, jpeg photo, treatment

orders, interview with a Registered Nurse (RN), Director of Care, (DOC). [000686]

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

The licensee failed to ensure that a resident had an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence and that the plan was implemented.

Rationale and Summary

A resident said some days they did not get changed and felt that some staff were not aware of what their care was relating to continence care. The Resident shared that they had experienced times when staff did not change them from morning until they went to bed in the evening.

The PSW reviewed the resident’s care plan, Kardex and Point-Of-Care tasks in Point Click Care. They said that the resident’s plan of care was not individualized to promote and manage bowel and bladder continence. They said that they were aware of the resident's preferences.

Failing to ensure that the resident had an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence, placed the resident at moderate risk as staff were not aware of the resident’s needs.

Sources: Resident clinical record, interviews with Resident, Personal Support Worker (PSW), Director of Care (DOC0. [155]

WRITTEN NOTIFICATION: Dealing with complaints

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3. ii. A.

The licensee has failed to ensure that their response to the person who had made a complaint concerning a resident’s care included an explanation of what the licensee had done to resolve the complaint.

Rationale and Summary

A complaint was made to the Ministry of Long-Term Care (MLTC) that concerns regarding a resident's care were not responded to by the home.

The Director of Care (DOC) stated that the home's process of following up with complaints included documenting, investigating, and contacting the Substitute Decision Maker (SDM) to provide information on what the licensee had done to resolve the issue. The DOC said that the resident's SDM was not contacted about their concerns regarding the resident's care.

Sources: Resident clinical record review, Family Complaint Tracker folder, interviews with Substitute Decision Maker (SDM), Director of Care (DOC). [000688]

WRITTEN NOTIFICATION: Recreational Cannabis

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 142 (1)

The licensee failed to ensure that a resident's recreational cannabis was stored in a locked box safely in their room or other location.

In accordance with O.Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that that there are written policies and procedures to govern, with respect to residents, the cultivation, acquisition, consumption, and administration, possession, storage and disposal of recreational cannabis in accordance with all applicable laws, including, without being limited to, the Cannabis Act (Canada) and the Cannabis Regulations (Canada), and must be complied with.

Rationale and Summary

A resident said that they kept recreational marijuana in their room.

The Director of Care (DOC) said that the resident did not have their recreational cannabis stored safely in a locked box as per the home's policy.

There was moderate risk with the resident's recreational cannabis not being stored as per policy as it was accessible to others.

Sources: Interviews with Resident and Director of Care (DOC), observations, review of Resident Recreational Marijuana policy RV-03-01-11. [155]