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

Immediate Compliance Order | Original Public Report

Report Issue Date: August 3, 2023
Inspection Number: 2023-1703-0003
Inspection Type: Complaint Critical Incident System
Licensee: CVH (No. 3) 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**
Janis Shkilnyk (706119)	Janis Shkilnyk Digitally signed by Janis Shkilnyk Date: 2023.09.07 18:36:42 -04'00'

Additional Inspector(s)
Katy Harrison (766)
Helene Desabrais (615)
Sharon Perry (155)

INSPECTION REPORT SUMMARY

The inspection occurred on the following date(s): July 31, August 1-3, 2023.

The following intake was inspected:

- Intake: #00090938-anonymous complaint regarding nursing and personal support services
- Intake: #00089923-complaint regarding resident going out of the home on a leave of absence

COMPLIANCE ORDER [ICO #902] Communication and response system

NC# 902 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (a)

The Inspector is ordering the licensee to:

FLTCA, 2021, s.155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act.

Compliance Order: [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with O. Reg. 246/22, s. 20 (a)

The licensee shall:

1. Conduct and document an audit on each pull cord alarm, call bell watch/bracelet and door alarms throughout the home. The audit must ensure that when a device is activated a notification is received to a staff member's electronic device showing where the alarm originated from and demonstrate the ability to clear the alarm at the point of activation. The audit must include that each watch/wrist alarm utilized by a resident is transmitted to an electronic device in the correct home area. The audit should include door alarms are not set to bypass.

2. Ensure that for all residents, the time at which the pull cord alarm, call bell watch/bracelet and door alarms monitoring system is activated is correlating to the home's internal reports. A documented audit of this record is to be kept available in the home.

Grounds

This order must be complied with by: August 10, 2023

The license failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

A) A resident was observed to be incontinent in their room with urine on the floor. No pull cord alarm was accessible to the resident. A resident stated that their wrist alarm did not work, had not worked for some time and that they had reported this to staff. The wrist alarm was tested

at the time of inspection and found not to be functioning. A resident's pull call alarm was observed to be positioned behind their bed and not accessible to the resident. A staff confirmed that their electronic device did not show a resident's wrist alarm ringing to their electronic device and did not know the process for getting the wrist alarm repaired. The following day a resident was observed to have no wrist alarm on and stated that staff had taken the alarm for repair.

Interim Executive Director (ED) said the call bell system was complicated.

The Director of Life Enrichment was unaware of any preventative maintenance for the home's call bell system. If staff found a device malfunctioning, they were to contact them and if they were unable, they thought another manager could make changes to the system and repair the device.

The home's policy stated that maintenance staff were to check the nurse call system as a routine part of the preventative maintenance program. They stated that managers were to check pull cord alarm, call bell watch/bracelet and door alarms function by completing walk abouts of the home areas.

Review of the home's complaint file documented a written complaint that a resident's wrist alarm did not work. Another complaint documented that staff were not carrying their electronic devices.

The home's management walk abouts did not include documentation of ensuing pull cord alarm, call bell watch/bracelet and door alarms, were functioning.

Not having a call/response system easily seen, accessed and functioning for a resident put residents in actual harm as staff were not aware of assistance a resident required related to their continence needs.

Sources: observations of a resident, policy-Nurse Call System, home's complaint file, home's management by walk about document, interviews with interim ED, Director of Life Enrichment, staff and a resident.

[706119]

B) A resident with exit seeking behavior was observed leaving a home area with a visitor and went to another living area. A staff checked their phone and there were no alerts showing that

a resident had left the home area. Later the resident returned to their resident home area and went into dining room.

A resident showed the inspector their call bell watch/bracelet on their left arm and said it did not work. The resident pressed the button on their call bell watch/bracelet. Staff did not respond. Staff showed the inspector their phone and no alerts had been sent to the phone for the resident.

A staff said they were told in report that the resident's call bell watch/bracelet was not working and stated that their supervisor for the floor was aware.

On another occasion the resident left their home area, walked down the hallway to another home area and then returned 14 minutes later.

The following day the resident left their home area, pushed their call bell watch/bracelet. It was not working. Staff confirmed there was no alerts on their phone showing for the resident.

Review of relevant reports showed that a stairwell door alarm was activated for several hours. The door was checked and was locked but noted to be on bypass. There was no audible alarm on the door. Staff confirmed the door was on bypass as when taken off bypass the door had an audible alarm that would not shut off. Staff stated they put in a maintenance request for repair.

Not having a call/response system easily seen, accessed and functioning for a resident put the resident at actual risk of harm as staff were not aware of their whereabouts or if they called for assistance as there were no alerts sent to the staff working in the resident's assigned living area.

Sources: observations of a resident, interviews with a resident, visitor, and staff, Director of Life Enrichment, call bell system reports.

[155]

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Monetary 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; or
(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.