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

Original Public Report

Report Issue Date: May 30, 2024	
Inspection Number: 2024-1703-0003	
Inspection Type: Complaint Critical Incident Follow up	
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 Gabriella Del Principe (741734)	Inspector Digital Signature Gabriella Del Principe Digitally signed by Gabriella Del Principe Date: 2024.06.13 08:42:32 -04'00'
Additional Inspector(s) Katy Harrison (766) Megan Brodhagen (000738)	

INSPECTION SUMMARY

The inspection occurred on the following dates: April 29-30, 2024, and May 1-3, and 6-10, 2024.

The following intakes were inspected in this Critical Incident (CI) Inspection:

- Intake #00112135, related to an outbreak
- Intake #00112387, related to staff to resident abuse

The following intakes were inspected in this Complaint Inspection:

- Intake #00110766, related to care concerns

- Intake #00112083, related to medication management and end of life care concerns
- Intake #00113578 and Intake #00113580, related to care concerns

The following Order was inspected:

- Intake #00111687 - Follow-up Compliance Order (CO) #001, related to continence care

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1703-0002 related to O. Reg. 246/22, s. 56 (2) (f) inspected by Katy Harrison (766)

The following Inspection Protocols were used during this inspection:

Skin and Wound Prevention and Management
Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 1.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's inherent dignity, worth and individuality, regardless of their race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability.

The licensee failed to ensure that a resident's dignity was considered while the resident was waiting for care to be provided.

Rationale and Summary

A resident was transferred from their personal washroom to their bed. The resident was placed in bed and left partially exposed for approximately 11 minutes, waiting for care to be completed.

The Skin and Wound Care lead indicated that the resident should not have remained exposed.

When the resident's body was partially exposed in between care, they were at risk of being negatively impacted.

Sources: Video footage, and interview with the Skin and Wound Care Lead. [741734]

WRITTEN NOTIFICATION: Plan of Care-Integration and Collaboration

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)
Plan of care
s. 6 (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The licensee failed to ensure that a resident's interdisciplinary care team collaborated with each other when nail concerns were identified.

Rationale and Summary

Review of the resident's records indicated that when a foot care assessment was completed, the provider indicated that the resident's toes had an infection and identified a recommended treatment option.

Further review of the resident's records demonstrated that the resident's interdisciplinary team were not informed of the resident's identified foot care concerns.

The Director of Care (DOC) indicated that there should have been collaboration between the foot care service provider and the nursing home staff, to ensure appropriate follow up, treatment and actions were taken at that time.

Failure of the interdisciplinary team to collaborate with one another prevented the resident from receiving treatment and care in a timely manner.

Sources: Resident's clinical health records and interview with the Director of Care. [741734]

WRITTEN NOTIFICATION: Plan of Care

NC #003 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.

A. The licensee failed to ensure that a resident received the correct fluid consistency at mealtime.

Rationale and Summary

The resident was provided with their meal and a Personal Support Worker (PSW) assisted the resident with their beverage and meal consumption. The PSW confirmed that the resident was provided a beverage that was not their required fluid consistency as per their plan of care. They believed that the beverage was already thickened to the required consistency. After the resident ingested a portion of the unthickened beverage, registered staff and the Physician were informed.

Failure to ensure that the resident received the correct fluid consistency resulted in the resident to cough at that time, which required immediate interventions by staff members.

Sources: Resident's clinical health records, and interviews with a PSW and Registered Nurse (RN). [741734]

B. The licensee failed to ensure that a resident's call bell placement was

implemented as per their plan of care.

Rationale and Summary

When staff members left the resident unattended in their room, the resident's call bell was not placed in their hands as per the direction in their plan of care.

Failure to ensure that the resident's call bell was placed in their hand placed the resident at risk.

Sources: Resident's clinical health records, video footage, and interviews with a PSW and the Falls Prevention and Management Lead. [741734]

WRITTEN NOTIFICATION: Plan of Care-Documentation

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
s. 6 (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care.

The licensee failed to ensure that documentation of care for a resident in relation to bathing was completed.

Rationale and Summary

An interview with a PSW indicated that resident's receive nail care, trimming and clipping, on their bath or shower days, and this would be documented in Point of Care.

A review of the resident's records demonstrated that during a three month period, there were eleven instances in which documentation was not completed on the

resident's scheduled bath days.

The Director of Care indicated that staff should have completed their documentation for all care provided to residents within Point of Care.

When the documentation for the provision of care was not completed for the resident, it prevented accurate monitoring of the care provided to the resident, to ensure that their care needs were sufficiently met.

Sources: Resident's clinical health records, and interviews with a PSW and the Director of Care. [741734]

WRITTEN NOTIFICATION: Foot care and nail care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 39 (1)
Foot care and nail care
s. 39 (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

The licensee has failed to ensure that a resident received preventative and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

Rationale and Summary

The resident's records demonstrated that during a four month period, staff did not document that basic footcare was completed.

Two months later, it was identified that the resident had infections to their toes and required treatment.

The Assistant Director of Care (ADOC) acknowledged that the resident did not receive foot care.

When staff did not provide foot care to the resident, there was potential impact to the resident's comfort and risk of infection.

Sources: Resident's clinical health records, images, and interviews with the ADOC and Executive Director (ED). [000738]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that the proper transferring device was used for a resident.

Rationale and Summary

A resident was transferred by two PSW's without following the directions on their Safe Lift and Transfer Assessment.

The Falls Prevention and Management Lead indicated that staff should have transferred the resident in the manner documented in the resident's plan of care.

Failure to ensure that the proper transferring device was utilized placed the resident

at risk of injury.

Sources: Video footage, resident's clinical health records, and interview with the Falls Prevention and Management Lead. [741734]

WRITTEN NOTIFICATION: Falls prevention and management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 246 / 22, s. 54 (1).

The licensee has failed to ensure that the falls prevention and management program provided strategies to reduce or mitigate falls, including monitoring, were implemented for a resident.

In accordance with O. Reg. 246 / 22, s. 11 (1) (b), the licensee is required to ensure that the home's Falls Prevention and Management program was complied with.

As per the home's Falls Prevention and Management Program, if a resident hits their head or is suspected of hitting head (e.g., unwitnessed fall), then complete a Clinical Monitoring Record.

Rationale and Summary

A resident was identified to have bruising and swelling on their head. An RN documented that the resident reported that they had fallen or thought they hit their head.

The RN confirmed that they did not complete a Clinical Monitoring Record on the resident, when they were identified to have a bruise and swelling on their head.

The Falls Prevention and Management Lead acknowledged that no Clinical Monitoring Record was completed on the resident and that this assessment should have been completed.

When staff did not monitor the resident's bruise and swelling, they were placed at risk of harm for not being properly monitored and provided the appropriate care.

Sources: Resident's clinical health records, The Home's Falls Prevention and Management Policy, and interviews with an RN and the Falls Prevention and Management Lead. [000738]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 55 (2) (b) (i)
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,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

A. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including bruising, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument.

Rationale and Summary

A resident was identified to have new bruises. An RN did not complete an initial skin and wound assessment.

The Skin and Wound Care Lead confirmed that the initial skin and wound assessment was not completed for the bruises identified and should have been.

Sources: Resident's clinical health records, Skin and Wound Program: Wound Care Management Policy, and interviews with staff members and the Skin and Wound Care Lead. [000738]

B. The licensee failed to ensure that a skin assessment was completed, using a clinically appropriate assessment instrument, for a resident, when altered skin integrity was observed.

Rationale and Summary

A review of the resident records indicated that a Registered Practical Nurse (RPN) observed excoriated skin on the resident.

The staff member that observed the altered skin integrity did not complete a skin assessment using a clinically appropriate assessment instrument. The staff member sent a referral to the Nurse Practitioner to inform them of the resident's altered skin integrity.

The Skin and Wound lead indicated that an assessment should have been completed when a newly identified skin concern was observed.

Failure to ensure that a skin assessment using a clinically appropriate assessment instrument was completed prevented the resident's interdisciplinary care team from assessing and addressing the altered skin integrity at that time.

Sources: Resident's clinical health records, and interview with the Skin and Wound Care Lead. [741734]