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: November 20, 2024

Inspection Number: 2024-1703-0004

Inspection Type:
Complaint
Critical Incident

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

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 8-11, 15-18, 22 and 23, 2024

The following intakes were inspected:

- Intake: #00118265 a complaint related to residents Bill of Rights and responsive behaviors.
- Intake: #00120169 a complaint related to meal times, medication administration, and temperatures.
- Intake: #00120910 and Intake: #00121381 were related to falls prevention and management.
- Intake: #00124043 complaint related to wound care.

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

Skin and Wound Prevention and Management
Continence Care
Resident Care and Support Services

Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 24 (1)

Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The Licensee has failed ensure that a resident was protected from sexual abuse by another resident.

For the purpose of this Act and Regulation, "sexual abuse" means: any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale

A resident had responsive behaviours towards another resident.

Staff witnessed an incident occurred on two separate occasions when a resident displayed responsive behaviours towards another resident.

The licensee failed to protect the resident from abuse on two different occasions by the other resident.

Sources: Review of the residents' clinical records, interview with PSWs and the home's policy titled Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct Policy dated August 2024

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

Complaints procedure — licensee

s. 26 (1) Every licensee of a long-term care home shall,

(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to ensure that a written complaint concerning the care of a resident was immediately forwarded to the Director.

Rationale and Summary

The long-term care home received a written complaint from a resident's family member that identified concerns related to the care the resident had received.

The Executive Director stated that the letter was not forwarded to the Director.

When the written complaint regarding the resident's care was not forwarded to the Director, it may have delayed the Director from responding to the complaint.

Sources: Complaint letter; Interview with the Executive Director.

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to report to the Director incidents of alleged abuse by a resident toward another resident.

Rationale
On two separate occasions, a resident displayed responsive behaviours towards another resident.

The Director was not notified of this incident of abuse as required.

Failure to report to the Director may have impacted the Director's ability to respond in a timely manner.

Sources: The home's policy titled Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct Policy dated August 2024 and Interview with DOC.

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (1) 4.

Skin and wound care
s. 55 (1) The skin and wound care program must, at a minimum, provide for the following:
4. Treatments and interventions, including physiotherapy and nutritional care. O. Reg. 246/22, s. 55 (1).

1) The licensee has failed to ensure the skin and wound care program was followed when a resident's wounds were treated by staff that did not have the proper training.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure there is a skin and wound program that has a process for treatments and interventions for wounds.

Specifically, the staff did not comply with the policy "Skin and Wound Program: Wound Care Management", which indicated that the role of care staff for wound care management was to report changes in skin integrity to the nurse, and to document altered skin integrity as per the homes process. The policy directed nursing staff to complete dressing changes for wounds.

Rationale and Summary
A resident had a skin tear that required an ordered treatment.

PSWs were providing the wound care intervention for the resident.

Multiple front line care staff stated that there was no process in the home for PSWs to provide wound care interventions. The Wound Care Champion stated that PSWs should not have be providing wound care to the resident.

When PSWs provided wound care to the resident without proper training, it put the resident's wound at risk for infection.

Sources: eTAR, Skin and Wound Program: Wound Care Management Policy dated October 2023; Interviews with front line staff, Wound Care Champion, Director of Care.

2) The licensee failed to ensure that the skin and wound care program were followed.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure there is a skin and wound program that has a process for treatments and interventions for wounds.

Specifically, the staff did not comply with the policy "Skin and Wound Program: Wound Care Management", which indicated that a resident exhibiting any form of altered skin integrity was to receive specified care as set out in their plan of care.

Rationale and Summary
A) A resident's plan of care identified that they had a wound and required specific interventions. Staff did not follow or implement the intervention that was prescribed for the resident's wound.

Staff stated that if there was a treatment order for a wound that order should have been followed.

B) A resident had a wound that had specific instructions of care. The resident's wounds were not cared for as directed on two different occasions.

Staff acknowledged that they should have followed the order for wound treatment and did not.

When the residents wound care treatments were not followed as ordered, there

was risk of the wound deteriorating.

Sources: Resident's physicians orders, eTAR, eTAR, progress notes, Wound Audit, Wound Care Management Policy dated October 2023; Interview's with staff.

WRITTEN NOTIFICATION: Skin and wound care

NC #005 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 has failed to ensure that a resident exhibiting altered skin integrity received immediate treatment and interventions to promote healing, and prevent infection.

Rationale and Summary
A) Staff did not re-assess the resident's wound for continuous treatment and the wound deteriorated.

No referrals to the Nurse Practitioner NP or Wound Care Champion were completed.

The Director of Care confirmed that assessment and referrals to the NP and Wound Care Champion should have been completed when the initial treatment order was completed.

When immediate treatment and interventions were not provided to the resident's wound this may have contributed to the residents wound deteriorating.

Sources: Resident's weekly skin assessments, wound photos, eTAR; Interview's with staff, Wound Care Champion, Nurse Practitioner and Director of Care.

B) The NP indicated that a wound swab was completed to determine the most appropriate treatment.

The result of the wound swab indicated that the resident was not receiving the most appropriate treatment. The NP changed the treatment and ordered the appropriate medication to treat the infection.

The order was written in the resident's chart but staff did not administer the medication to the resident on one occasion.

The Director of Care indicated that there was a delay in treating the resident's wound with an ordered treatment and should have been started when it was first identified.

When there was a delay in treating the resident's wound as ordered, they were at risk of their wound infection worsening.

Sources: Resident's physicians orders, culture and sensitivity report, progress notes, eMAR; Interview's with Nurse Practitioner and Director of Care.

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
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,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee has failed to ensure that a resident with altered skin integrity was reassessed at least weekly.

Rationale and Summary
A resident's weekly skin assessment was not completed in full on one occasion. The assessment was missing detailed information including any required referrals which could have prevent the wound from deteriorating.

The Director of Care indicated that the expectation was the weekly skin assessments were to be completed in full. They indicated staff are expected to complete a referral to the Wound Care Champion regarding the deterioration of the wound.

By failing to complete the weekly skin assessment in full, including any referrals required, the resident's wound was not effectively monitored.

Sources: Resident's weekly skin assessments, wound photos; Interview's with staff and DOC.

WRITTEN NOTIFICATION: Dining and snack service

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a

dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure food was being served at a temperature that was both safe and palatable to the residents.

Rationale and Summary
The Food Service Manager (FSM) stated that temperatures of food were to be taken twice prior to every meal, in the kitchen and home area servery prior to serving the residents.

There were no temperatures of the food taken at the servery on two occasions.

The home's policy titled "Temperature of Food at Point of Service" stated that food temperatures are to be taken before serving, in a manner that promotes comfort and safety.

Failure to take the temperature prior to the meal placed residents at risk for consuming food that was not safe and palatable.

Sources: Interview with staff, October 2024 Food Temperature Logs, Home's policy titled "Temperature of Food at Point of Service"

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication

incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

The licensee has failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Rationale and Summary
Registered staff were not administering prescribed medication that were not included in the resident's medication pouches from the pharmacy until they were reminded by the resident.

The home's policy titled "Medication Incident Reporting" stated that healthcare staff must report, and document all identified medication incidents or near misses on a Medication Incident/Near Miss Report form or electronically.

This incident was not documented as per the home's policy.

Failure to document the medication incident put the resident at risk for future medication incidents, as potential interventions could not have been implemented.

Sources: Interview with RPN, Policy titled "Medication Incident Reporting Policy"

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (b)

Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee has failed to ensure that every medication incident involving a resident was reported to the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider.

Rationale and Summary
A nurse had a near miss incident when administrating medication to a resident. The nurse retrieved the missing medication and administered to the resident upon noticing it. The nurse stated that this incident was not reported to anyone.

Failure to inform the required persons about the medication incident put resident at risk for future medication incidents, as potential interventions could not have been implemented.

Sources: Interview with RPN, Policy titled "Medication Incident Reporting Policy"

COMPLIANCE ORDER CO #001 Policy to promote zero tolerance

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (2) (e)

Policy to promote zero tolerance
s. 25 (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with FLTCA, 2021, s. 25 (2) (e)

The licensee shall:

A) Revise the home's zero tolerance of abuse and neglect policy to include procedures for investigating and in particular, responding, to alleged, suspected or witnessed incidents of abuse of a resident. At minimum, the content must include procedures for assessing a resident's capacity to consent to physical touching, including providing guidelines or procedures for staff to assist them in determining whether the touching or remarks of the nature of the abuse among residents is consensual or non-consensual. Additionally, there should be a process to document how consent was determined after each incident.

B) Ensure all staff and management team are provided training on the revised zero tolerance for abuse and neglect policy, specifically as it relates to responding to alleged, suspected, or witnessed sexual abuse of a resident. This includes the procedure to determine consent.

Grounds

The Licensee failed to ensure the home's zero tolerance of abuse and neglect policy included procedures for how staff respond to an incident of resident to resident abuse. Specifically, it did not include procedures to determine and document whether both residents consented to the act.

For the purpose of this Act and Regulation, “abuse” means: any non-consensual touching, behaviour or remarks of abuse or exploitation directed towards a resident by a person other than a licensee or staff member.

Rationale
A resident was noted to have specific behaviours.

Staff witnessed incidents involving the resident and another resident. There was no assessment or documentation to determine whether the other resident understood what they were consenting to or whether they had the ability to consent.

Staff were to confirm consent for physical touching and document it as instructed in the PSWs task list. This confirmation did not explain how staff were to determine whether the resident could consent. The Home's policy on zero tolerance of abuse and neglect, did not have direction on how staff were to determine or confirm consent to physical touching.

Failure to have a procedure to determine whether a resident can consent to the act, puts the resident at risk of being exposed to unwanted behaviours.

Sources: Review of the residents' clinical records. Interview with staff, DOC and ADOC. The home's policy on zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct" policy created on August 2024.

This order must be complied with by January 23, 2025

COMPLIANCE ORDER CO #002 Responsive behaviours

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The license shall:

A) Conduct an internal multidisciplinary team meeting that includes all staff, management team and NP/MD to discuss the resident's responsive behaviours. Ensure that strategies are developed and a plan is developed on how to implement the identified strategies in relation to resident's responsive behaviours.

B) Conduct an in-depth assessment of the responsive behaviour as provided in the home's policy and consult with the interdisciplinary team to develop resident specific interventions to address the identified responsive behaviours.

Grounds

The licensee failed to ensure that interventions are re-evaluated and implemented for a resident's responsive behaviours.

Rationale
A resident was exhibiting specific behaviours towards other residents in the home.

There was no re-evaluation of interventions that were implemented for the resident when there were multiple incidents indicating that their responsive behaviours escalating.

As a result the home not developing and implement interventions to manage the resident's responsive behaviours, vulnerable residents on the unit were placed at risk.

Sources: Review of the residents' clinical records, Interview with staff. The home's responsive behaviour policy reviewed 2024.

This order must be complied with by January 6, 2025

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 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.
(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.