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

Ottawa District
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: June 12, 2023
Original Report Issue Date: May 25, 2023
Inspection Number: 2023-1819-0001 (A1)
Inspection Type: Complaint Critical Incident System
Licensee: CVH (No. 7) 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 Kemptville, Kemptville

Amended By	**Inspector who Amended Digital Signature**
Manon Nighbor (755)	Manon Nighbor Digitally signed by Manon Nighbor Date: 2023.06.12 11:52:53 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Reflect the Written Notifications numbering correction made from WN #001, #002, #004, #005 to WN #001, #002, #003, and #004.

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Amended Public Report (A1)

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Long Term Care Home and City: Southbridge Kemptville, Kemptville	
Lead Inspector Manon Nighbor (755)	**Additional Inspector(s)**
Amended By Manon Nighbor (755)	**Inspector who Amended Digital Signature** Manon Nighbor Digitally signed by Manon Nighbor Date: 2023.06.12 11:53:22 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Reflect the Written Notifications numbering correction made from WN #001, #002, #004, #005 to WN #001, #002, #003, and #004.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 4, 18, 19, 21, 25-28, 2023 and May 1, 2023.
The inspection occurred offsite on the following date(s): May 3, 2023

The following intake(s) were inspected:

- Intake: #00022861 -Complaint related to shortage of staff, bathing, fall, responsive behaviours, communication and response system. Water system was reviewed.
- Intake: #00022999 - [Critical Incident System (CI) :3060-000005-23] related to restraints.

On April 4, 2023, Inspectors Saba Wardak and Maryse Lapensee were present during the inspection.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home
Staffing, Training and Care Standards
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

AMENDED 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 has failed to ensure that the following the provision of the care set out in the plan of care were documented.

1-Rationale and summary:

A resident's plan of care indicated that they received their bath twice weekly.

Within a period of a couple of months, there were no record documented related to the resident's bath for 17 days and the third month, there were only two baths recorded that month.

Several staff members confirmed that when they are short staff, residents received a bed bath, and they did not have sufficient time to document the bed baths provided to the residents.

2-Rationale and summary:

A second resident's plan of care stated that the resident received their bath twice weekly.

Within a period of four months, there were 14 days where there was no record documented that the resident had received their bath.

3-Rationale and summary:

A third resident's plan of care stated that the resident received their bath twice weekly.

Only one bath was documented in one month, two baths were documented the following month and there was no bathing record the next month.

As such, the provision of the three residents' baths were not documented.

Sources: Several residents' health record and interviews with several staff members and a resident. [755]

WRITTEN NOTIFICATION: Communication and response system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (b)

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that, is on at all times.

Rationale and summary:
The home's resident-staff communication and response system was called Momentum, it included android phones by the Caterpillar (CAT) name brand. The Tag was also another handheld device included in the system. The Tag's functions were for staff members to press red button for emergencies, yellow button for assistance and green button to clear notifications. When a resident called for assistance, the audible notification would be audible on each of the staff member's CAT phone who worked in the resident's care area and the notification would be cancelled at the resident's bedside. If the notification had not cleared, then the green button on the Tag device would clear it.

Two staff members explained that their CAT phones were inconsistent. They said there was a time when they could go a whole shift, without any notifications. In a conversation with two staff members who worked on the same resident's care area, the inspector observed that one staff member received less notifications on their CAT phone than the second staff member. Another staff member stated that sometimes they could not clear the notifications and explained that since they could not clear the notifications, it appeared like they had not attended to the resident and the resident could not further

call for assistance until their previous notification was cleared. A different staff member added that sometimes they have received notifications from residents living on other units.

The staff member who is the assigned resource person for Momentum in the home said they were looking at the Tags, since notifications were not being cleared to ensure the batteries did not require replacement. They had assisted staff members to restart and sign into their phones and sometimes they were required to call for technical assistance (IT). They added that sometimes the internet reception, especially in the extremities of the building was not always reliable and that the night staff were found turning their phone ring setting off.

Another staff member was observed in the dining room without their phone because the batteries had died and when they obtained their phone, they could not access their notifications because they were not signed into the system. When inspector initiated the notification communication system from a resident's bedroom, a staff member received the notification approximately five minutes later.

As such, the communication and response system not functioning all the time may impact residents' care delivery and is a potential risk for residents' safety.

Sources: Inspector's observations and interviews with several staff members.

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WRITTEN NOTIFICATION: Hazardous substances

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 97

The licensee has failed to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

Rational and summary:
The Environmental Services Manager confirmed that a hazardous substance was left in a resident's living area, by a member of the Environmental Services Team. A resident was found in a position suggesting they may have ingested the hazardous substance. The resident was sent to hospital and underwent investigations. The resident did not sustain any ill effect, from the incident.

As such, a hazardous product was not kept away from residents' access and paused a safety risk to a resident's health.

Sources: The resident's health record and interview with staff members.

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WRITTEN NOTIFICATION: Prohibited devices that limit movement

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 121 6.

The licensee has failed to ensure that any device that cannot be immediately released by staff are not used in the home.

Rational and summary:
A resident's plan of care indicated that they required an incontinent brief at night. The resident was known to have responsive behaviours.

A staff member confirmed that when they started their morning shift, they found the resident lying in their bed sleeping. The staff member was not able to immediately remove the resident's bedsheet covering the resident. The sheet was tied to the mattress keeper bar, located on the bed platform on one side and looped to the mattress keeper bar on the other side of the bed.

The staff member shared that, they were told from the particular staff member that had tied and looped the sheet that they had intended to prevent the resident from accessing their continent briefs.

As such, the resident's bedsheet, covering them, prevented them from reaching their continent brief and could not be immediately released by staff.

Sources: Critical Incident System and interview with staff members and Director of Care.

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