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 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: November 28, 2023

Inspection Number: 2023-1819-0006

Inspection Type:
Complaint
Critical Incident
Follow up

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

Lead Inspector	**Inspector Digital Signature**
Kelly Boisclair-Buffam (000724)	Kelly Boisclair-Buffam Digitally signed by Kelly Boisclair-Buffam Date: 2023.12.01 15:24:43 -05'00'

Additional Inspector(s)
Manon Nighbor (755)
Gurpreet Gill (705004)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 20, 23, 25, 26, 27, 30, 31, 2023 and November 1, 2, 2023

The following follow-up intake(s) were inspected:

· Intake: #00094959 - FLTCA, 2021 - s. 5 related to door alarms.
· Intake: #00094960 - O. Reg. 246/22 - s. 96 (2) (h) related to water temperatures .
· Intake: #00094961 - O. Reg. 246/22 - s. 20 (b) related to communication system.

The following critical incident report (CIR) intake(s) were inspected:

· Intake: #00097344 - (CIR 3060-000038-23) related to a fall with injury.
· Intake: #00099003 - IL-18446-AH/CIR 3060-000041-23 related to an unexpected death.
· Intake: #00098887 - (CIR 3060-000040-23) related to skin and wound.

The following complaint intake(s) were inspected:

· Intake: #00098795 - related to door accessibility

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #002 from Inspection #2023-1819-0002 related to O. Reg. 246/22, s. 96 (2) (h) inspected by Kelly Boisclair-Buffam (000724)

Order #002 from Inspection #2023-1819-0003 related to O. Reg. 246/22, s. 20 (b) inspected by Manon Nighbor (755)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:
Order #001 from Inspection #2023-1819-0002 related to FLTCA, 2021, s. 5 inspected by Gurpreet Gill (705004)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Safe and Secure Home
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Conditions of licence

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
Licensee must comply
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with compliance order (CO) #001, inspection #2023-1819-0002 served on August 18, 2023, with a Compliance Due Date (CDD) of September 18, 2023.

Rationale and Summary

As per O. Reg. 246/22, s. 12 (1) 1 (iii), all doors leading to stairways and to the outside of the home or doors that residents do not have access to, must be equipped with an audible door alarm.

In October, 2023, the Inspector found deactivated door alarms with key slots in the consoles positioned horizontally at the following doors: Stairwell C/level 2, Stairwell E/level 2, and "staff-only" door (leading to the back of the laundry and kitchen areas). The inspector held all three doors open for several minutes, and there was no audible alarm.

Staff indicated that the door alarm (stairwell E/level 2) should have sounded if the door had been kept open for several minutes.

The Environmental Consultant demonstrated to the inspector that, in order to cancel an active door alarm, a key is used to turn the alarm key slot to the right and into a horizontal position. The Environmental Consultant also confirmed that the key slot must be in the vertical position after resetting the door alarm in order to reactivate it.

As such, there was a potential risk to residents having unsupervised access to stairwells and the "staff-only" back door leading to the laundry and kitchen areas, in the event that any of the referenced doors failed to close properly.

Sources: Observations and staff and Environmental Consultant interviews. [705004]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Plan of care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
Documentation
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 has failed to ensure that the care set out in the plan of care was documented.

Rationale and Summary

A resident developed skin integrity impairment. The resident's treatments and monitoring were not documented in the Electronic Treatment Administration Record (ETAR).

A-The resident's ETAR indicated the skin impairment care requirements and the required days for skin assessments.

The inspector found no documentation in the ETAR and leading up to the discontinuation of the treatment.

B-The resident's ETAR indicated the skin impairment care requirements, were to assess and cover with a dressing on a specific time of day.

The inspector found no documentation in the ETAR and leading up to the

discontinuation of the treatment.

C-The resident's ETAR indicated the specific skin impairment care requirements: to assess and change the dressing on specific times of the day. The products to be used were also specified.

The inspector found no documentation in the ETAR, leading up to the discontinuation of the treatment. There was a date specified where the skin had healed, and the treatment was discontinued.

There was a reoccurrence of skin integrity impairment. The resident's new ETAR requirements were to monitor the skin impairment changes, the products to be used and the days for dressing changes.

There was no documentation found in the ETAR that the dressing was monitored.

A month later, the skin impairment requirements and assessments to be completed were updated.

The inspector found no assessment records or dressing monitoring documentation. The treatment was discontinued.

The skin impairment had progressed further. The care requirements were updated and there was no documentation that the dressing had been verified .

In an interview, two staff members confirmed that the skin impairment monitoring and dressing changes should have been documented in the ETAR and as required.

As such, the lack of consistent treatment and monitoring documentation in the resident's ETAR, may have increased the risk of affecting other areas of the skin.

Sources: ETAR, skin and wound progress notes and assessments, point of care, care plan, interviews with staff members.
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WRITTEN NOTIFICATION: Skin and wound care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(ii) upon any return of the resident from hospital, and

The licensee has failed to ensure that, a resident exhibiting altered skin integrity, including pressure injuries receives immediate treatment and interventions to promote healing, and prevent infection, as required.

Rationale and Summary

A resident developed multiple breakdowns to the skin.

According to the Skin and Wound Program, Prevention of Skin Breakdown, Policy RC-23-01-01, on going procedures stated:

- A Pressure Ulcer Scale Healing (PURS) is completed quarterly during a RAI MDS reassessment and when clinically required to ensure risk is mitigated and strategies and interventions are implemented to address areas of risk or actual skin impairment.
- A comprehensive interdisciplinary plan of care is implemented for resident with a PURS score greater then three.
- A referral to other members of the interdisciplinary team is indicated.
- Notification to the Wound Care Lead, is indicated.
- Contact the physician for residents with compromised skin injury.
- The resident's plan of care is updated and integrated across all disciplines.

On a specific day in August 2023, a resident's skin injury reoccurredand progressed. A few days later , PUSH assessments were initiated. No referrals or updates with the external Wound Care Champion, the Physician and the Registered Dietician were documented, during the wound assessments a month later.

The skin injury had enlarged with further deterioration. A note was left for the physician, a referral to the external Wound Care Champion and the Registered Dietician were also made at that time.

The following month, the skin injury had progressed even further. The resident was prescribed antibiotics and an intervention to support skin integrity. The resident had other health ailments that required hospitalization.

A staff member confirmed that the physician should have been consulted sooner or the nurse should have documented if they consulted with the physician.

The employee also added that the home had conducted a Pressure Ulcer Risk Score (PURS) as per the Resident Assessment Instrument Minimum Data Set (RAI MDS) prior to the skin deteriorating.

The residents impaired skin integrity written plan of care, did not demonstrate any revision for two months.

A staff member indicated that they were currently providing skin and wound care education to the registered staff to respond to skin and wound care in an interdisciplinary integrated approach.

As such, the lack of immediate treatment and interventions to promote healing, and prevent infection potentially contributed to the rapid progression of the resident's changes in skin condition.

Sources: RAI MDS, Head to Toe, weekly skin assessments. Registered Dietician, Physicians and skin and wound care related notes, Skin and Wound Program Policy RC-23-01-01 last reviewed October 2023 and interviews with staff members.

[755]

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