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

Public Report

Report Issue Date: December 19, 2024

Inspection Number: 2024-1819-0007

Inspection Type:
Complaint
Critical Incident

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 12-13, 16-18, 2024.

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake: #00131476, CI #3060-000053-24 - related to Disease Outbreak

The following intakes were completed in this complaint inspection:

- Intake: #00132308 and Intake: #00132390 - related to resident care concerns

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

Continence Care
Falls Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Medication Management
Palliative Care
Resident Care and Support Services

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.
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 has failed to ensure that a resident's provision of care as set out in their plan of care, was documented.

Specifically, there was no documentation in the resident's Medication Administration Record (MAR) on two specific dates in September 2024, regarding the administration of a medication and care of a medical device.

Sources: Resident's electronic health care record, and interview with a Registered Practical Nurse (RPN), and other staff.

The licensee has failed to ensure that a resident's provision of care as set out in their plan of care was documented.

Specifically, there were multiple dates in December 2024 where tasks for a resident were not signed off by the Personal Support Worker (PSW) providing care to the resident, including bathing, Activities of Daily Living (ADL's), pain and fall monitoring.

Sources: Resident's health care records, interviews with a PSW and RPN.

WRITTEN NOTIFICATION: Required Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to ensure that when a resident experienced a fall in November 2024, that the resident's SDM was notified as soon as possible.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure the home has in place a falls prevention and management program to reduce the incidence of falls and the risk of injury, and that it is complied with.

Specifically, staff did not comply with the requirements outlined on the homes Fall Prevention and Management Program document (RFC-07-01) that stated that the resident's SDM should be contacted "as soon as possible after the fall." The resident's SDM was not notified until a couple of days after the fall.

Sources: Interview with the DOC and an RPN, review of resident's clinical records and Fall Prevention and Management Program policy (RFC-07-01).

WRITTEN NOTIFICATION: Continence care and bowel management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (h) (i)

Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,

The licensee has failed to ensure that a resident was provided with the continence care products based on their individually assessed needs.

Specifically, a resident was wearing the wrong size continence care product on a date in December 2024. A PSW confirmed that the resident was not wearing the continence product based on his assessed needs. Upon further observation by an Inspector, the resident's continence care product was not available anywhere on the unit.

Sources: Resident's health care records, observations made of the resident, interview with a PSW.

WRITTEN NOTIFICATION: Pain Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that a resident was assessed using a clinically appropriate tool specifically designed for pain management after they fell in November 2024, leading to pain management concerns related to an injury that was not identified for 12 days post-fall.

Sources: Interview with Director of Care, Staff, Review of medical record pain assessments, resident progress notes, medication administration record, and LTCH *Pain Management Policy RFC-03-21*.

WRITTEN NOTIFICATION: Reports re critical incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.
Reports re critical incidents
s. 115 (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (5):
4. Subject to subsection (4), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

The licensee has failed to ensure that after a resident experienced a fall in November 2024, and was subsequently sent to the hospital 11 days later, a report was made to the Director within one business day of the resident's return to the home with an injury.

Sources: Interview with DOC, resident health care record.

WRITTEN NOTIFICATION: Safe storage of drugs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,

(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and

The licensee has failed to ensure that a resident's drugs were stored in an area used exclusively for drugs that is secured and locked or in a medication cart.

Specifically, prescribed ointment for a resident was found in the resident's room and not in the medication cart. The RN confirmed at time of observation that this medication should not have been in the resident's room.

Sources: Observations made in resident's room and medication cart in December 2024 and interview with RN.

WRITTEN NOTIFICATION: Administration of drugs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that two ointments were applied to a resident as specified by the prescriber.

Specifically, the RN confirmed that a resident did not receive two ointments as

ordered in December 2024.

Sources: Resident's medication administration record and interview with RN.