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: August 18, 2023	
Inspection Number: 2023-1819-0002	
Inspection Type: Post-Occupancy	
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 Megan MacPhail (551)	**Inspector Digital Signature** Megan K MacPhail Digitally signed by Megan K MacPhail Date: 2023.09.25 10:17:45 -04'00'
Additional Inspector(s) Manon Nighbor (755) Jessica Lapensee (133)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 13, 14, 15, 20, 21, 22, 23, 27, 28, 29 and 30, 2023.
The inspection occurred offsite on the following date(s): July 18, 2023.

The following intake(s) were inspected:
Intake: #00089682 - Post Occupancy Inspection for Southbridge Kemptville.

WN #001 related to FLTCA, 2021, s. 19 (2) (a) was identified in a concurrent inspection, #2023-1819-0003 (intake 00088752), and issued in this report.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Safe and Secure Home

Infection Prevention and Control
Staffing, Training and Care Standards
Admission, Absences and Discharge

INSPECTION RESULTS

WRITTEN NOTIFICATION: Accommodation Services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)

The licensee has failed to ensure that the home and equipment were kept clean and sanitary.

Rationale and Summary

A) In three (3) resident bathrooms, the Inspector observed multiple bedpans and urine collection hats (UCHs) on the floor that were dirty and visibly soiled.

Additional observations were made in randomly selected resident bathrooms with a focus on personal care equipment such as bedpans, urinals, UCHs and wash basins. Unsanitary conditions were found, with dirty personal care equipment stored on bathroom floors in 11 additional bedrooms.

The Inspector met with the Infection Prevention and Control (IPAC) lead to discuss the dirty personal care equipment on floors in bathrooms. The IPAC lead confirmed that personal care equipment was to be removed from the bedroom once used, cleaned, disinfected and stored in a sanitary manner, and that it was not appropriate to store such items on the bathroom floor.

The home's policy stated that staff must properly clean and disinfect all dedicated and non-dedicated resident personal care equipment after each use to prevent the spread of infection. The personal care equipment was to be stored in a clean and sanitary manner, in the residents' bedroom or clean utility area.

Residents were impacted as the personal care equipment being used by staff was not clean and sanitary, and there was risk related to the spread of infection.

B) The Inspector observed randomly selected resident bedrooms with a focus on overall cleanliness. Areas of concern were identified in 17 resident rooms. All areas of concern were observed again that evening, and in the company of the Administrator and the Environmental Services Manager (ESM) the following day (with two exceptions).
Examples of observed trends included:

· Lower walls and baseboards to the side of and behind toilets were dirty and visibly soiled;
· Exterior areas on toilets were dirty and visibly soiled;
· Bathroom and bedroom floors (including fall mats) were sticky and/or dirty with accumulated debris;
· Lower walls in bedrooms were dirty and visibly soiled;
· Other: Privacy curtains were dirty with dried matter, tops of overbed rolling tables were dirty and visibly soiled, comfortable easy chairs (provided by the home) were dirty and visibly soiled.

The Administrator and ESM indicated that the observed conditions were not acceptable.

This impacted residents as their environment was not being kept clean and sanitary.

Sources: Observations and interviews with the ESM and other staff.

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WRITTEN NOTIFICATION: Directives by Minister

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that the Minister's Directive: COVID-19 Guidance Document for Long-Term Care Homes was followed with regards to masking requirements.

Rationale and Summary

The Minister's Directive, in effect at the time of the inspection, stated that all staff, students, support workers and volunteers were required to wear masks and applicable personal protective equipment when interacting with residents.

A staff was observed working with a resident while their mask was under their nose.

The IPAC Lead stated that the staff member's mask should have been covering their nose when interacting with the resident.

Not wearing a mask properly may have increased the risk of viral transmission.

Sources: Minister's Directive: COVID-19 Guidance Document for Long-Term Care Home and interview with the IPAC Lead.

[551]

WRITTEN NOTIFICATION: Doors in a Home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. i.

The licensee has failed to ensure that all doors leading to stairways were kept locked.

Rationale and Summary

A stairway door on the second floor was not locked. The ESM indicated that a recent power outage may have affected the magnetic locking system.

A door technician came on-site to fix the door.

This was a risk to residents as the unlocked door allowed for unrestricted and unsupervised access to the stairway.

Sources: Observation and interview with ESM.

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WRITTEN NOTIFICATION: Nutrition Manager

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 81 (2)

The licensee has failed to ensure that a Nutrition Manager (NM) was an active member of the Canadian Society of Nutrition Management (CSNM) or that they were actively pursuing their CSNM membership.

Rationale and Summary

A staff worked part time as a nutrition manager.

They were in the process of planning to enroll in a CSNM accredited program in Food Service and Nutrition Management.

The staff worked in the role of nutrition manager without being an active member of the CSNM or actively pursuing their membership. The transitional staffing flexibility provision (section 388) that allowed licensees the flexibility to hire nutrition managers with relevant experience and skills expired April 11, 2023.

Sources: Interview with staff and Ministry of Long-Term Care Staffing Qualifications Fact Sheet (20230406).

[551]

WRITTEN NOTIFICATION: Maintenance Services

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (g)

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that the temperature of the water serving all bathtubs, showers, and hand basins used by residents did not exceed 49 degrees Celsius.

Rationale and Summary

Hot water temperatures in excess of 49 degrees Celsius (C), ranging from 50.9C to 55.1C, were found in dining room hand basins and showers. The Administrator indicated there was an ongoing challenge with water not being warm enough, not too hot, and that plumbers and engineers had tried to resolve the issue of low water temperatures.

On a different day, hot water temperatures in excess of 49 degrees C, ranging from 51.8C to 56C, were found in hand basins and showers.

The Administrator and Southbridge Director of Operations and Resident Experience stated that options for corrective action had been discussed, and that further efforts would be made to determine if there were underlying issues with the hot water system. The temperature of the hot water boilers had been elevated to 62C in the past to rectify the problem of not enough hot water in the home. The temperature of the boilers was reduced to lower water temperatures throughout the home.

A maintenance worker indicated that they monitored water temperatures once during the day shift. Of the documented water temperatures in the daily water temperature log, 57% were above 49C. All weeks had numerous instances of water temperatures above 49C, and it was documented that the boiler temperature was 62C. There were six days where all documented water temperatures were below 49C.

On a different day, water temperatures exceeding 49C, ranging from 50.2C to 54C, were found throughout the home. The Administrator informed the Inspector that on an HVAC technician had put the boiler temperature back up to 62C after completing an intervention that the technician believed would permanently address the water temperature challenges at the home. The Administrator confirmed that the intervention had not been successful, and the boiler temperature had been turned down.

The temperature of the water serving all showers and hand basins exceeded 49 degrees Celsius, and this put all residents at risk of being scaled.

Sources: Observations, interviews with staff and review of water temperature monitoring logs.

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WRITTEN NOTIFICATION: Maintenance Services

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (i)

The licensee has failed to ensure that procedures were developed and implemented to ensure that the temperature of the hot water serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius (C).

Rationale and Summary

A PSW indicated that after they bathed a resident at a comfortable temperature early in the morning, they could not bathe other residents due to a lack of hot water. The water in residents' bathrooms was too cold to use to provide proper care. When the water was too cold for bathing, they brought a resident to the hairdressing room so they could wash the residents' hair.

A second PSW indicated that they bathed a resident in bath water that was cool as the resident needed to be cleaned, and the resident did not show any signs of discomfort. The PSW indicated that cool water and fluctuating temperatures had been problematic.

A resident, who had a bath that morning, stated that the temperature of the water was not comfortable. They liked a hot bath.

The Inspector found that the temperature of the hot water serving three showers and two bathtubs was below 40C. The range was from 34.3C to 36.8C.

Water temperature graphs generated by the building automation system showed water temperatures spiking up and dropping down, with numerous periods of time when the temperature dropped below 40C.

Water temperatures below 40C impacts residents in that personal care cannot be reliably provided with comfortable water temperatures for baths, showers and bed baths.

Sources: Observations, interviews with a resident staff and review of water temperature graphs.

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WRITTEN NOTIFICATION: Maintenance Services

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (k)

The licensee has failed to ensure that procedures were developed and implemented to ensure that the water temperature was monitored once during the evening shift and once during the night shift.

Rationale and Summary

The Inspector measured hot water temperatures throughout the home, and temperatures above 49 degrees Celsius (C) were found.

A maintenance worker indicated that they monitored water temperatures, at hand basins in three activity rooms and in three resident bedrooms, once during the day shift in the morning between approximately 0800 and 0900 hours. Documented water temperatures were provided to the Inspector.

Through interviews with the Administrator, DOC and ESM, it was confirmed that there was no procedure in place to monitor water temperatures during the evening and the night shift. A new procedure was implemented to cover the monitoring of water temperatures on all three shifts (day, evening and night).

There was risk to residents as staff were not aware of water temperatures on the evening and night shifts.

Sources: Observations, interviews with a maintenance worker and other staff and review of weekly water temperature logs.

[133]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

The licensee has failed to ensure that a resident was isolated as required.

Rationale and Summary

A resident was isolated with enhanced precautions in place as they were symptomatic of infection. Their RAT was negative, and their PCR test was pending.

The resident walked to the dining room and ate their lunch meal at a table with three co-residents. The resident was redirected to their room to eat dessert after the RN verified that the resident was under isolation.

A memo stated that as per Southbridge policy, when a resident was symptomatic, the resident was to be isolated with Enhanced Precautions in place immediately. A RAT was to be performed and PCR collected. The resident (and room-mate, if had one) was to be isolated until the PCR returns.

The IPAC Lead stated that the resident should have been isolated in their room and not eating lunch in the dining room.

By not following isolation measures, viral transmission may have occurred.

Sources: Observations of the inspector and interview with the IPAC Lead.

[551]

COMPLIANCE ORDER CO #001 Home to be Safe, Secure Environment

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 5

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

1. Ensure that the alarm for each door leading to stairways and each door leading to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident remain active.

To meet the requirement of step (1):
A) Develop and implement a written procedure to ensure that access to the key(s) that are used to reset alarms is controlled.
B) Require that any staff that use an accessible alarm key, such as the key kept in the maintenance room, sign off on having done so and attest to ensuring that the door alarm was reactivated after being reset.
C) Conduct daily documented visual audits, including on holidays and weekends, of all of the referenced doors to confirm that the alarms are active. Ensure there is no key in the alarm console, and that the key slot in the console is in a vertical position.
D) Document any follow up action taken when it is found that a key was left in the alarm console or the door alarm was not active due to the position of the key slot. Determine who was responsible for leaving the key in the console or for leaving the alarm deactivated. Audits and related documentation shall continue until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

E) Require staff at the reception desk to document that they have verified that the front door alarm is active at the beginning of their shift and any time they return from a period of time away from the reception desk (e.g. after lunch break). Verifications and related documentation shall continue until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

2. Ensure that unsupervised access to all non-residential areas is restricted for residents.

To meet the requirement of step (2):
A) Ensure that keys for doors to non-residential areas are not accessible to residents at any time.
B) Conduct documented daily audits, including on holidays and weekends, to ensure that all doors leading to non-residential areas are kept closed and locked (unless being directly supervised by staff) and that there is no key in the door handle. The documented daily audits shall continue until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to ensure that the home was a safe and secure environment for its residents in relation to deactivated door alarms and accessibility of non-residential areas.

Rationale and Summary

A) The Inspector found that the alarm for the front door was inoperable. A key was in the door alarm console next to the door, in a horizontal position. The door was held open for several minutes and there was no audible alarm.

As per O. Reg. 246/22, s. 12 (1) 1 iii, all doors leading to stairways and to the outside of the home must be equipped with an audible door alarm.

The Inspector found deactivated door alarms at the following doors: stairway C1 (key in the console), stairway C2, stairway D2, stairway E3 (key in the console), stairway E2, stairway B1 (key in the console). The Administrator and ESM indicated there should not be keys in the alarm consoles, and that the key slot in the console had to be in the vertical position for the alarm to activate when the door did not close after a certain period of time. Door alarms were reset, and the keys were removed by the Administrator and ESM.

The Inspector found that the alarm for the front door was inoperable a second time. The door was held open for several minutes, and there was no audible alarm. The alarm key was not in the console, and the position of the key slot was horizontal.

All residents were at risk of unsupervised access to stairways and to the outside of the home in the event that any of the referenced doors did not close properly.

B) The Inspector found keys hanging on long cords next to doors leading to non-residential areas throughout the home. Examples include housekeeping closets and storage rooms containing hazardous cleaning products, garbage chute rooms and laundry chute rooms with unrestricted access to the chutes within, clean and soiled utility rooms and linen cart storage rooms. In some cases, the key was unattached to the cord and was in the door lock.

As per O. Reg 246/22, s. 12 (3) all doors leading to non-residential areas must be equipped with locks in order to restrict unsupervised access to those areas by residents. By having keys immediately available at the doors, or in the door handles, unsupervised access to the non-residential areas was not restricted.

The Administrator informed that the hanging keys were a temporary solution as the home was not provided with a supply of keys that could be cut for the doors upon opening. The keys had been received, however the keys hanging on cords next to doors leading to the non-residential areas, had not been removed.

All of the keys were removed.

All residents were at risk of unsupervised access to non-residential areas throughout the home.

Sources: Observations and Interview with the Administrator.

[133]

This order must be complied with by September 18, 2023

COMPLIANCE ORDER CO #002 Maintenance Services

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (h)

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

1. Review water temperature trend graphs (hourly intervals) as generated by the Building Automation System every morning by 9:00 am and every afternoon at approximately 4:00pm, including on holidays and weekends.

2. Print and retain the two daily trend graphs (hourly intervals) until the Ministry of Long- Term care has deemed that the licensee has complied with this order. Sign and date each graph to support that a member of the management team has reviewed them. Include the time of review.

3. Conduct a daily audit of the hot water temperature log(s) that are required to be completed by staff in the home on each shift. The auditing of the daily logs shall continue until the Ministry of Long-Term Care has deemed that the licensee has complied with this order. Include a signature, date and time to support that a member of the management team has conducted a daily audit of the log(s), including on holidays and weekends.

4. Develop a written procedure that includes immediate action to be taken to reduce the water temperature, should the temperature of the water exceed 49 degrees Celsius.

5. Document all actions taken should the temperature of the water exceed 49 degrees Celsius, including the immediate action(s) taken to reduce the water temperature in order to ensure there is no risk to the residents.

6. Ensure that all staff are educated about the risk of scalding when the temperature of the hot water exceeds 49 degrees Celsius with a focus on the increased risk to long-term care home residents (e.g. skin integrity, cognitive impairment). Document the information provided to staff, the method(s) used to educate staff, and record the names of all staff that receive the education. This must include all staff from temporary staffing agencies.

Grounds

The licensee has failed to ensure that procedures were developed and implemented to ensure that immediate action was taken to reduce the water temperature when it exceeded 49 degrees Celsius.

Rationale and Summary

The Inspector found hot water temperatures exceeding 49 degrees Celsius (C), ranging from 51.7C to 55.1C, in dining room hand basins and showers. The Administrator and DOC were made aware of the elevated water temperatures.

Immediate action was not taken to reduce the water temperature when it exceeded 49C, as two days later, the Inspector found hot water temperatures exceeding 49C in hand basins and showers. The range was from 51.8C to 56C.

The Administrator and Southbridge Director of Operations and Resident Experience stated that options for corrective action had been discussed, and that further efforts would be made to determine if there were underlying issues with the hot water system. The temperature of the hot water boilers had been elevated to 62C in the past to rectify the problem of not enough hot water in the home. The temperature of the boilers was reduced to lower water temperatures throughout the home.

A maintenance worker indicated that they monitored water temperatures once during the day shift, at three activity room sinks and three resident bedrooms. The maintenance worker indicated that they look for a range of 45C to 50C. The maintenance worker said that for months, cool water flowed from the taps, and they were now seeing temperatures of 51-52C.

Daily water temperature logs were reviewed, and of the documented temperatures in the daily log, 57% were above 49C. All weeks had numerous instances of water temperatures above 49C, and it was documented that the boiler temperature was 62C. There were six days where all documented water temperatures were below 49C.

Immediate action was not taken to reduce the water temperature when it exceeded 49C. All residents were at risk of scalding as a result.

Sources: Observations, interviews with a maintenance worker, the Administrator and other staff and review of water temperature monitoring logs.

[133]

This order must be complied with by September 18, 2023

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.