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 7, 2023

Inspection Number: 2023-1819-0004

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**
Karen Buness (720483)	Karen Lynne Buness Digitally signed by Karen Lynne Buness Date: 2023.11.16 15:28:12 -05'00'

Additional Inspector(s)
Margaret Beamish (000723)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 26, 27, 28, 29, 2023 and October 3, 4, 5, 6, 2023

The following intake(s) were inspected:

- Intake: #00094962 - Follow-up #: 1 - O. Reg. 246/22 - s. 52 (1) (a) Qualifications of Personal Support Workers
- Intake: #00091590 - Complaint related to staffing levels
- Intake: #00093895 - Complaint related to plan of care and staffing levels
- Intake: #00096446 - Fall of resident resulting in a significant change in health status
- Intake: #00091885 - Fall of resident resulting in a significant change in health status
- Intake: #00092361 - Fall of resident resulting in a significant change in health status
- Intake: #00092628 - Fall of resident resulting in a significant change in health status
- Intake: #00092833 - Fall of resident resulting in a significant change in health status
- Intake: #00094330 - Fall of resident resulting in a significant change in health status
- Intake: #00094348 - Alleged resident to resident sexual abuse
- Intake: #00096670 - Alleged resident to resident sexual abuse

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1819-0003 related to O. Reg. 246/22, s. 52 (1) (a) inspected by Karen Buness (720483)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that a resident's written plan of care provided clear direction to staff and others who provide direct care to the resident. Specifically, the resident's documented care plan, kardex, and progress notes which are parts of the plan of care, did not contain clear direction for interventions that were in place for managing the resident's sexually responsive behaviours.

Rationale and Summary:
Incidents of witnessed sexual abuse occurred by a resident towards another co-resident on a certain date one month and on a certain date in another month. A third incident of sexual abuse occurred by the same resident towards a different co-resident on a certain date.

The responsive behaviours section of the resident's care plan and kardex were reviewed by Inspector #000723, and contained the following interventions to manage the resident's sexually responsive behaviours:

- Staff to ensure an intervention to deter other residents from wandering into their room was in place.
- Have Dementia Observation System (DOS) checks every 15 minutes completed by staff to ensure no sexually responsive behaviours are presenting. Staff to monitor behaviours, record findings on DOS record sheets, and report responsive expressions immediately to registered staff on duty.

On several dates, the resident was observed in their room and the intervention to deter other residents from wandering into their room was not in place. This intervention was initiated after the first witnessed incident of sexual abuse.

As per the resident's progress notes, care plan, and kardex, the DOS observation checks intervention was initiated on a certain date for continued monitoring of the resident's sexually responsive behaviours after the initial five day DOS monitoring that was started directly after the incident. DOS observation sheets were located for a certain time period. No DOS observation sheets were located for the time period before the third incident of sexual abuse that occurred by the resident towards a different co-resident. DOS observation sheets could also not be located for the time period prior to the inspection date.

Two Personal Support Workers (PSW) and a Registered Practical Nurse (RPN) stated that the intervention to deter wandering was not used often since a co-resident was internally transferred to another home area and there were currently no other residents with wandering behaviours on the home area.

A PSW and an RPN stated that the DOS observation checks every 15 minutes intervention was not occurring anymore but could not recall when this intervention stopped.

An Assistant Director of Care (ADOC) stated that if an intervention is listed in a resident's care plan, then staff should be using it. The ADOC confirmed that the intervention to deter wandering was still an ongoing intervention. The ADOC stated that the DOS observations checks every 15 minutes intervention would usually only be used for a short period of time and then stopped. The ADOC stated that end dates for interventions are usually identified in a resident's progress notes as this is how the home communicates this information to staff. The ADOC reviewed the resident's progress notes with Inspector #000723 and confirmed that there was no direction given for an end date to this intervention.

Failing to ensure that the plan of care provided clear direction to staff potentially increased the risk of a resident not receiving the interventions they required to manage their sexually responsive behaviours and to protect other residents.

Sources: a resident's progress notes, care plan, kardex, DOS observation sheets, observations, interviews with staff.

[000723]

WRITTEN NOTIFICATION: Responsive behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

The licensee has failed to ensure that when a resident demonstrated responsive behaviours, that actions were taken to respond to the resident's needs, including assessment, reassessments, interventions, and that the resident's responses to interventions are documented.

Rationale and Summary:
A review of a resident's plan of care identified that the resident exhibits sexually responsive behaviours. On a certain date, an incident of sexual abuse occurred by the resident towards another co-resident. The resident was started on Dementia Observation System (DOS) monitoring post incident for five days.

On a certain date, the resident's progress notes indicated that the resident was to then start DOS observation checks every 15 minutes for continued monitoring of sexually responsive behaviours. The resident's care plan and kardex were both updated to include this intervention, with no end date provided.

Inspector #000723 reviewed the DOS observation sheets for a certain time period and noted that documentation was not completed for nine out of eighteen shifts during that time period. Additionally, there were no DOS observation checks completed for the time period before the third incident of sexual abuse by the resident towards a different co-resident. There were also no DOS observation checks completed for the time period prior to the inspection. This intervention was still listed in the resident's plan of care at the time of inspection.

A PSW and an RPN stated they were no longer completing the DOS observation checks intervention but could not recall when this intervention stopped.

An ADOC stated that the DOS observation checks would usually only be used for a short period of time and then stopped. However, the ADOC acknowledged that there was no end date provided for this intervention and confirmed that the DOS observation checks with missing entries should have been completed.

As such, failure to follow the intervention of DOS observation checks as identified in the resident's plan of care potentially increased the risk of the resident's sexually responsive behaviours not being fully analyzed and evaluated, placing other residents at risk.

Sources: a resident's progress notes, care plan, kardex, DOS observation sheets, interviews with staff.

[000723]