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
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Original Public Report

Report Issue Date: January 29, 2024

Inspection Number: 2023-1819-0007

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**
Lisa Kluke (000725)	Lisa Kluke Digitally signed by Lisa Kluke Date: 2024.02.27 10:35:48 -05'00'

Additional Inspector(s)
Gurpreet Gill (705004)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: December 6 to 8, 11, 12, 15, 18 to 22, 27 to 29, 2023 and January 3, 2024.
The following intakes were inspected:
Follow-ups:
• Intake: #00102901 -Follow-up #2 to compliance order for FLTCA, 2021 -s. 5 related to doors.
• Intake: #00101264 -Follow-up #1 to compliance order for O. Reg. 246/22 - s. 55 (2) (b) (iv) related to skin and wound care.
• Intake: #00101265 -Follow-up #1 to compliance order for FLTCA, 2021 -s. 6 (7) related to plan of care.

Critical Incidents:
• Intakes: #00099828 and #00100715 were related to resident falls resulting in a significant change in condition.
• Intake: #00100399 was related to an unexpected death of a resident.
• Intakes: #00101713 and #00101745 were related to written complaints to the home regarding issues with care and services provision.
• Intake: #00102240 was related to alleged staff to resident abuse.
• Intake: #00102780 was related to alleged resident to resident abuse.

Complaints:
• Intake: #00100281 was a complaint related to resident care and services.
• Intake: #00101185 was a complaint related to an incident of alleged staff to resident abuse, and an incident of alleged resident to resident abuse.
• Intake: #00101947 was a complaint related to care and services, skin and wound care and Infection Prevention And Control (IPAC) related concerns for donning and doffing of Personal Protective Equipment (PPE) as required.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1819-0002 related to FLTCA, 2021, s. 5 inspected by Lisa Kluke (000725)
Order #001 from Inspection #2023-1819-0005 related to FLTCA, 2021, s. 6 (7) inspected by Lisa Kluke (000725)
Order #002 from Inspection #2023-1819-0005 related to O. Reg. 246/22, s. 55 (2) (b) (iv) inspected by Lisa Kluke (000725)

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
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 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan related to interventions required after a specific procedure.

Rationale and Summary:
On a specified date, this resident returned from a procedure with instructions for staff to perform specific interventions as part of their after procedure care.

The Acting Director of Care (DOC) indicated that these interventions were not completed after this procedure. It was the Registered Practical Nurse's (RPN) responsibility to perform these interventions for the resident during their reassessments.

As such, not providing these interventions after this procedure as per aftercare interventions written in the instructions for this resident, could have increased the risk of harm to the resident.

Sources: Resident's health care records and interview with the DOC. [705004]

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
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 provision of the care set out in a resident's plan of care was documented.

Rationale and Summary:

The Point Of Care (POC) documentation for this resident showed that for a specified month, there were four days, where this resident's meal and fluid intake at breakfast and lunch were not documented, and three days where supper and snacks were not documented. Over another two-week period the following month, there was one day, when the resident's meal and fluid intake at breakfast and supper were not documented, and four days where lunch was not documented.

The Assistant Director of Care (ADOC) indicated that the resident received their meal and fluids, but it was not documented in POC.

By failing to ensure that the documentation of the provision of care set out in resident's plan of care regarding meal and fluid intake in POC, may pose a potential risk of harm in the evaluation of residents' nutrition and hydration monitoring.

Sources: Resident's health care records and interview with the ADOC. [705004]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that when a Registered Nurse (RN) was informed that an allegation of staff to resident physical abuse had occurred, they immediately reported their suspicion and the information upon which it was based to the Director.

Rationale and Summary:
On a specified date, the Director received a complaint regarding an alleged staff to resident physical abuse that occurred the day prior. The complainant reported hearing this resident calling out from the hallway, and then observed two Personal Support Workers (PSW's) attempting to dress the resident's upper body in bed, while holding down the agitated resident by their wrists. The complainant indicated the PSW's caring for this resident noted them at the door and stopped holding down the resident at this time. The complainant reported this resident indicated to them that they were not happy with the care that was provided and were very upset. The inspector reviewed this resident's progress notes for the date of the incident and an RN documented this allegation was reported to them and they assessed the resident to have bruises noted to both wrists. This RN completed an internal incident report for the Director of Care (DOC) and slid this report under their office door.

On a date approximately seven weeks later, the Acting Director of Care indicated they recalled this incident and was aware that a nursing staff member had reported this allegation of staff to resident physical abuse and an investigation began immediately, however this was not reported to the Director immediately, as required.

Sources: Resident health care record, Critical Incident System report, interviews with the complainant and the Acting DOC. [000725]

WRITTEN NOTIFICATION: Policies, etc., to be followed, and records

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)
Policies, etc., to be followed, and records
s. 11 (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

The licensee has failed to ensure that where the Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place regarding any policy and procedure for resident to staff call response system, the licensee is required to ensure that their policy and procedure is complied with.

Rationale and Summary:
The Administrator provided the inspector the home's Extendicare Policy and Procedure manual as reference for the home's policies. Policy RC-08-01-01- Nurse Call System states: ensure that all care staff respond to alarms in a timely and courteous manner. This policy and procedure for this system was last revised November 2023.

On a specified date, a resident reported to the inspector about an incident that occurred approximately seven weeks prior, when they called nursing staff for assistance to their bedroom at in the evening hours that took a long time to respond to their needs.

On this same date, another resident reported to the inspector about an incident that occurred the day before when they called nursing staff for assistance to their bedroom during the night shift hours that took 27 minutes to respond to their needs. Eight days later, this resident reported about another incident that occurred four days prior whereby they had fallen before the evening shift change and used their nurse call system that took approximately 40 minutes to respond to their needs.

A Restorative Care Manager indicated they could not locate the call identified by the first resident in their system, and that possibly the resident misused the nurse call systems devices or they malfunctioned. The incidents for the second resident were confirmed for both occasions, and they indicated the home's expectations was staff responding to the nurse call system in a timely and courteous manner, which is 15 minutes for all care staff. The home has set up the nurse call system so that all calls made by residents go to the Personal Support Worker's (PSW's) phone systems. If these calls are not responded to and cancelled after 15 minutes, the nurse call system is then redirected to registered nursing staff in this home area to respond. This nurse call system has reports sent to the Assistant Directors of Care and Director of Care daily with a list of nurse call system response times for the units they are responsible for on the previous day for review and follow up.

An Assistant Director of Care (ADOC) indicated being aware of the second resident's concerns for nurse call response times and that Personal Support Workers and Registered Nursing Staff reviewed the home's policy and procedure for responding to resident's calls for assistance using the nurse call system.

Sources: Resident interviews, Restorative Care Manager and an ADOC interviews and audit record reviews for nurse call response system. [000725]

WRITTEN NOTIFICATION: Falls prevention and management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.

The licensee has failed to ensure that when a specified resident had fallen, that a post fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary:
On a specified date, this resident had an unwitnessed fall that resulted in an injury and was transferred to the hospital the following day. A review of the resident's health care records confirmed that no post fall assessment was found for this resident's fall on the date of the falls incident.

An Assistant Director of Care (ADOC) indicated that a post fall assessment was not completed at the time of the fall for this resident and mentioned that Registered Nursing staff are supposed to complete a post fall assessment after each fall.

Failure to ensure a post-fall assessment was completed after this resident's fall, posed a risk of not identifying any potential harm and implementation of interventions for this resident in a timely and appropriate manner.

Sources: A resident's health care records and interview with an ADOC. [705004]

WRITTEN NOTIFICATION: Infection Prevention And Control Program

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to implement the Infection Prevention And Control (IPAC) Standard issued by the Director with respect to infection prevention and control measures for a specified resident.

The home failed to ensure additional precautions, as part of the IPAC program, was followed by staff when providing care in accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes April 2022" (IPAC Standard).

Specifically, proper Personal Protective Equipment (PPE) was not selected when providing personal care for this resident who required specific IPAC control measures as required in the Additional Precautions requirement 9.1 (d), under the IPAC Standard.

Rationale and Summary:
On a specified date, a Personal Support Worker (PSW) was observed at a resident bedside preparing to perform personal care to this resident who was on specific

precautions. It was observed that this PSW was only wearing two of the three PPE required while at the resident's bedside. This resident had signage for specific precautions at their bedside and PPE was available outside the resident's bedroom for staff who are required to provide personal care. The IPAC lead was coming down the resident hallway and an inspector inquired if PSW's are required to wear a specific PPE item when providing personal care to this resident. The IPAC lead entered this resident's room and confirmed that this PSW was not wearing the proper PPE when personal care was provided to this resident, as per their specific precaution requirements.

Not properly selecting appropriate PPE increases the risk of transmission of infectious agents to nursing staff and other residents.

Sources: Observation on a specified date and an interview with the IPAC lead. [000725]

The licensee has failed to implement the IPAC Standard issued by the Director with respect to infection prevention and control measures for the resident hand hygiene program.

The home failed to ensure additional precautions, as part of the IPAC program, was followed by staff when providing care in accordance with the "Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes April 2022" (IPAC Standard).

Specifically, ensuring the hand hygiene program for residents included the provision of assistance to residents to perform hand hygiene before meals and snacks; as required in the Additional Precautions requirement 10.2 (c), under the IPAC Standard.

Rationale and Summary:
On a specified date, an inspector observed two of the 28 residents in one of the home area's dining room, offered assistance with hand hygiene before the lunch meal service.

The next day, this inspector observed in another home area dining room, one resident completed hand hygiene on their own as there was a bottle of foaming hand sanitizer located on their table before the lunch meal service. No other residents in this home area were observed to be offered or assisted with hand hygiene before the lunch meal.

The IPAC lead indicated to the inspector that all residents are to be offered hand sanitizer at the start of the meal service in the dining rooms, with the available hand hygiene station stand at the entrance of each dining room, as well as portable bottles available in each home area dining room. These portable bottles and hand hygiene stations were seen located in each home area; however they were not seen used for each resident in those dining rooms observations.

Not properly assisting residents before meal services with their hand hygiene, increases the risk of transmission of infectious agents to residents.

Sources: Lunch meal observations, interview with the IPAC lead. [000725]

The licensee has failed to ensure that Infection Prevention and Control (IPAC) standard issued by the Director was followed by staff related to hand hygiene as required by Routine Practices.

Rationale and Summary:
On a specified date, an inspector observed a Personal Support Worker (PSW)

assisting a resident with their lunch while simultaneously documenting on their tablet in one of the home area's dining room. After closing the tablet, this PSW proceeded to assist a resident seated at another table. While helping this resident with feeding, this PSW touched the resident and their wheelchair. Subsequently, this PSW assisted another resident at the same table. This PSW did not perform hand hygiene before and after assisting different residents, and before and after touching residents and their wheelchairs.

On this same date, the inspector observed a second PSW touch a resident who was eating lunch, grabbed the used small cup in front of them, and placed it closer to another resident. Subsequently, this PSW picked up a small disposable cup with a straw and assisted another resident at the same table in drinking with the straw. This second PSW did not perform hand hygiene after picking up the used empty cup and before assisting another resident with their drink.

On this same date, the inspector observed that another staff member assisting a resident with feeding, then stood up and grabbed a dessert for another resident and served it to them. This staff member did not perform hand hygiene before picking and serving a dessert to another resident.

Four days later, the inspector observed that a third PSW brought two residents in their wheelchairs into a specified home area dining room, and positioned their wheelchairs near the table, and then brought in another resident, also in a wheelchair, positioned their wheelchair near the table. This third PSW did not perform hand hygiene before and after touching each of the residents' wheelchairs.

On this same date, the inspector observed a fourth PSW bring a resident in a wheelchair into this same home area dining room and positioned the resident's wheelchair near the table. This PSW also assisted another resident, who was

walking with their walker, to sit in a dining chair and moved the resident's walker to the side. This PSW did not perform hand hygiene before and after touching the residents and their walker. Afterward, this PSW brought another resident in a wheelchair and pushed a dining chair to the side to position the resident's wheelchair near the table. Subsequently, PSW positioned and adjusted the wheelchairs of the other two residents who were at the same table. This fourth PSW did not perform hand hygiene between these residents.

On this same date, a fifth PSW was observed assisting multiple residents with their clothing protectors, touching residents' wheelchairs, and residents' hair and neck area in this home area dining room. Subsequently, this PSW assisted a resident who was walking in the dining room to sit in their dining chair. This fifth PSW did not perform hand hygiene between coming into contact with multiple residents while applying clothing protectors to different residents and before and after touching residents and their wheelchairs.

On this same date, the second PSW, was observed assisting multiple residents with their clothing protectors, touching residents' wheelchairs and residents' hair and neck area in the Iris unit dining room. The PSW did not perform hand hygiene before and after applying clothing protectors to different residents, and before and after touching residents.

During interviews with these PSWs and a specified staff member, they confirmed that they forgot to sanitize their hands and indicated that they are supposed to sanitize their hands between residents.

The Infection Prevention and Control (IPAC) lead indicated staff must follow the four moments for hand hygiene: before and after contact with the resident or resident's environment, and in between residents.

As such, a lack of hand hygiene and not following the four moments for hand hygiene between resident interactions could increase the risk of infection transmission among residents and staff.

Sources: Observations and interviews with PSWs, a specified staff member and the IPAC lead. [705004]

NOTICE OF RE-INSPECTION FEE Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
Intake#00102901 had one order for doors that is now complied.

Licensees must not pay a Re-Inspection Fee 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 Re-Inspection Fee.