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

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| Report Issue Date: November 21, 2024 |
| Inspection Number: 2024-1819-0006 |
| Inspection Type:<br>Complaint<br>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): October 22, 23, 24, 25, 28, 30, and 31, 2024, and November 4, 5, 6, 7, 8, 12, 13, and 14, 2024

The following intake(s) were inspected:

- Complaint intake #00124889, #00126048, and #00129040 - lack of supplies and continence products in the home;
- Complaint intake #00127481 and #00129609 - availability of supplies and incontinent products for a specific resident;
- Critical Incident intake #00129061 (CI #3060-000052-24) - alleged staff to resident abuse;
- Complaint intake #00130564 - concerns regarding resident and staff relationship; and
- Complaint intake #00131418 - training and qualifications of registered nurses

The following Inspection Protocols were used during this inspection:

Continence Care
Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure that a resident's right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act. Specifically, on multiple occasions the resident's personal health information was shared with another

person without the resident's consent.

Sources: resident's health records, and Interviews with the resident, and Social Services Worker.

## WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee has failed to ensure that the written plan of care for two residents set out clear directions to staff and others who provide direct care to the residents, specifically related to incontinence products.

Multiple internal plan of care tools related to the residents continence care needs, specifically incontinence care products, were not consistent and clear for the staff to meet the two residents individual needs.

Sources: Resident's health care records, Resident Worksheet, and interview with Director of Clinical Services, a PSW, and staff.

## WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance

s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

The licensee's policy Zero Tolerance off Resident Abuse, Neglect and Unlawful conduct (revised August 2024) stated that suspected abuse witnessed by a staff person must immediately be reported to their supervisor, and if the supervisor is the suspected perpetrator of the abuse, then the staff person must immediately report to the Director of Care / designate.

The incident of verbal abuse and alleged physical abuse towards a resident occurred on a specific date. The incident was reported to the Director of Care and designate two days later.

Sources: Critical Incident #3060-000052-24, Zero Tolerance off Resident Abuse, Neglect and Unlawful conduct (Policy # RFC-02-01, Revised August 2024), interview with a Personal Support Worker (PSW) and the Director of Care (DOC).

## WRITTEN NOTIFICATION: Bathing

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless

contraindicated by a medical condition.

The licensee has failed to ensure that a resident received, at a minimum, their twice weekly bath during a specified week.

Sources: resident's plan of care; resident's Documentation Survey Report; Unit Bath List; interview with a PSW and other staff.

## WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee has failed to ensure that a Registered Practical Nurse (RPN) used safe transferring and positioning techniques with a resident when the resident was assisted with their mobilization and positioning to another area of the home.

Sources: Video surveillance record, interview with the Director of Care (DOC).

## WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 56 (2) (a)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

The licensee failed to ensure that a resident, who is incontinent, had received a continence assessment since their admission to the home a couple of years earlier.

Sources: Extendicare Continence Management Program RC-14-01, Extendicare Continence Assessment Appendix A, Southbridge Continence Care Policy RFC-05-01, resident's health care record, interview with Director of Clinical Services, and Director of Care.

## WRITTEN NOTIFICATION: Menu Planning

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 77 (4) (b)
Menu planning
s. 77 (4) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and

The licensee has failed to ensure that a between-meal beverage in the morning was offered to each resident on a resident home area on a specific date. A PSW stated that there was no morning beverage offered to the residents because of time constraints.

Sources: Observation of unit, review of records, and interview with PSW.

## WRITTEN NOTIFICATION: Dining and Snack Service

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 79 (1) 1.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.

The licensee has failed to ensure that the dining service included communication of the seven-day and daily menus to residents, specifically related to beverages.

Recent changes were made to the home's dining service regarding the beverages offered at lunch and dinner. The Dietician Consultant explained that the goal of the change was to ensure that the beverages being offered were those on the menu. However, the menus communicated to the residents did not include the beverages that would be offered at breakfast, lunch, and dinner.

Sources: Observations of dining room weekly and daily menus; Extendicare Communication of Menus Policy NC-05-01-04, last reviewed March 2021; Menus from October 21 to 25 and October 28 to Nov 1, 2024; and interview with Dietician Consultant, Food Services Manager, resident, and other staff.

## COMPLIANCE ORDER CO #001 Availability of Supplies

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 48

Availability of supplies
s. 48. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
1.The licensee shall:
a) Develop and implement a written procedure to ensure that supplies - including shower gel, silicone barrier cream, and moisturizer, are readily available in the home for use by staff and residents, to meet the nursing and personal care needs of the residents in the home. The procedure shall include, at a minimum,
i) Determine a sufficient amount of supplies that are required to meet the nursing and personal care needs of all residents;
ii) Ensure the above supplies are readily available to residents and direct care staff on each resident home area (RHA);
iii) A formalized process for requesting additional supplies, such as shower gel, silicone barrier cream, and moisturizer; ensuring that the requested supplies are provided in a timely manner to direct care staff in order to meet the nursing and personal care needs of the residents.

b) Conduct audits three times a week on the availability of personal care supplies on each resident home area (RHA) - including shower gel, silicone barrier cream, and moisturizer; ensuring that the supplies are readily available to meet the personal needs of the residents.

c) Take any corrective action necessary as a result of the audits; and

d) Provide documentation to support that action has been taken in regard to (a) through (c), and any other action that the home determined was necessary in order to ensure that supplies were readily available to meet the personal care needs of

the residents.

Documentation is to continue until such time that the Ministry of Long-Term Care has deemed that the licensee has complied with this Compliance Order.

2.The licensee shall:
a) Conduct a review of the organized laundry program to ensure that a sufficient supply of face cloths, peri cloths and towels are readily available in the home for use by staff and residents, to meet the nursing and personal care needs of the residents in the home. The review shall include, at a minimum,
i) complete a linen inventory count of the entire home;
ii) determine the amount of linens required for every resident, every shift;
iii) determine which residents have any degree of independence in regards to their personal care and ensure that on every shift those residents have the linen supplies they need;
iv) develop and implement written procedures to ensure a sufficient, readily available quota, for every shift, and every resident;
v) develop and implement a formalized process for requesting additional clean linen, such as face cloths, peri cloths, and towels.

b) Conduct audits three times a week on the availability of clean linen on two RHA's - including face cloths, peri cloths, and towels; ensuring that the supplies are readily available to meet the personal needs of the residents.

c) Conduct twice weekly audits of residents who are independent with care on an RHA, completing a different RHA each week, including all shifts, to ensure that each independent resident has the required number of linens as determined in step ii) to

meet their personal care needs. Continue audits until this order has been complied;

d) Take any corrective action necessary as a result of the audits; and

e) Provide documentation to support that action has been taken in regard to (a) through (d), and any other action that the home determined was necessary in order to ensure that linen supplies were readily available to meet the personal care needs of their residents.

Documentation is to continue until such time that the Ministry of Long-Term Care has deemed that the licensee has complied with this Compliance Order.

Grounds

1.The licensee has failed to ensure that supplies were readily available at the home to meet the personal care needs of residents; specifically shower gel, silicone barrier cream, and moisturizer.

Both the Director of Care and Director of Clinical Services stated that personal care supplies are stocked in the clean utility room of each resident home area (RHA) and that any additional stock is located in the resident care storage room on a different RHA. Over several days, three RHA clean utility rooms had no stock of all or some of the following personal care supplies: shower gels, silicone barrier creams, and moisturizers. There was also no additional stock observed in the resident care storage room. In addition, an RPN stated that the resident care storage room had not been stocked with shower gel, silicone barrier cream, and moisturizer for some time.

Sources: Observations of three RHA's; and interview with Director of Clinical Services, Director of Care, PSW's, and an RPN.

2.The licensee has failed to ensure that supplies, specifically face cloths, peri cloths, and hand towels, were readily available at the home to meet the nursing and personal care needs of residents.

On several different dates, there was a lack of linen supplies on multiple RHA's; including some, or all, of the following: face cloths, peri cloths, hand towels, and soaker pads. As a result, a PSW completed the provision of care to their residents using large bath towels and another PSW completed their resident care using hand towels. Both indicated that this is a recurrent issue and that they have had to use paper towel on residents for care in the past.

At another time on a specific date, there were no face cloths, peri care cloths, small towels or pog cloths on an RHA. Multiple residents stated that they did not receive face cloths and towels for which to do their morning care, and two PSW's stated they used large bath towels or paper towel to complete the care on their residents. The above residents, and their family members, indicated that they have had to buy their own face cloths, hand towels, and peri wipes as the home did not have enough supply. One of the residents stated that the previous week they had not received any new towels or face cloths, so they had saved the same towel for a week to ensure they would have something to use. Another resident stated they had a face cloth and towel in their room, however, they were no longer there after breakfast. They explained that because their room is close to the tub room, staff often come and take their linens for residents getting their baths.

A Laundry Aide confirmed that all RHA's have their two linen carts stocked every morning with all available linens to last a 24 hour period, however, this occurs at different times in the morning and it's often not enough to meet the residents needs. They explained that a PSW left their unit to come request additional white face cloths on a specific date but they had none to give them. They went on to state that this is a regular occurrence.

Sources: observations of linen carts and clean utility rooms on two RHA's; linen stock room; central storage personal care room; interview with an RN, three PSWs, Laundry Aide, three residents, and other staff.

This order must be complied with by February 6, 2025

## COMPLIANCE ORDER CO #002 Continence Care and Bowel Management

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246 / 22, s. 56 (2) (f)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with O. Reg. 246 / 22, s. 56 (2) (f) [FLTCA, 2021, s. 155 (1) (b)]: The plan must include but is not limited to:

a) The development and implementation of a written procedure to ensure that each resident who is incontinent is assessed so that the home's supply is based on the residents' individual assessed needs.

b) The development and implementation of a written procedure that will ensure that the above supply of products are readily available and accessible to residents and direct care staff on all shifts within the resident home areas (RHA).

c) The provision of training to all nursing staff, including members of the leadership

team about the procedures required in part (a) and (b) of this order.

d) Conducting documented, three times a week audits for one month to ensure the efficacy of the procedures required in part (a) and (b). Audits related to part (b) shall be conducted on a different RHA weekly, alternating shifts.

e) Conducting documented, three times a week audits, for one month to ensure that residents are wearing the correct incontinent product as described in their plan of care. The audit must be conducted on a different RHA weekly, alternating shifts, and must include six residents. The audit must be completed on a different RHA than the audits required in part (d).

f) Conducting documented weekly audits after the process prescribed in part (d) and (e) has concluded until such time that the Ministry deems this Compliance Order to have been complied with.

g) The documentation of any concerns found as a result of the audits described in part (d) and (e) with corrective actions taken as required, in order to demonstrate the progressive nature of these corrective actions.

h) Maintain documentation to support compliance with all required actions as specified in this order, and continue documenting actions taken until such time that the Ministry of Long Term Care deems this order to be complied.

Please submit the written plan for achieving compliance for inspection #2024-1819-0006 to MLTC, by email to ottawadistrict.mltc@ontario.ca by December 5, 2024. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

The licensee has failed to ensure that several residents had a sufficient quantity of continence care products available and accessible for all required changes at specific times during a one month period.

On several specific dates, multiple resident's correct incontinent product size was not available at their bedside, in the clean utility room 24-hour supply cupboard of their home area, or in the clean supply overflow storage unit for the home. PSW, Registered staff, and maintenance staff of the home have expressed that since 3 months ago there has been a lack of supply of incontinence products at the home, and residents are placed in whatever product is available at the time of their required change. A PSW explained that a specific resident often needs to be left on a pad as they do not have the right product available to place on the resident.

On a different date, a couple residents were placed in incorrect incontinent care products as the correct product was not available in the resident's room or in the clean utility room 24-hour supply cupboard of their home area. A PSW stated they did not have time to follow the process of requesting the correct product from registered staff, and as a result placed the resident in something other than what was listed in their plan of care.

On another specified date, a resident was placed in the incorrect incontinent care product as the correct product was not available. The PSW assigned to the resident indicated that many residents were placed in the wrong product that shift as there was no supply available in the building.

On another specified date, a resident was placed in an incorrect incontinent care product as the correct product was not available. The 24-hour brief supply was not yet delivered to the unit as the home's incontinence product order had not yet been delivered to the home by their supplier.

Sources: Observations of four RHA's; three resident rooms; Resident Worksheets; six residents plans of care; Kemptville Prevail Process document, July 28, 2024; Night Shift PSW Sign off Document; Daily Duties for night shift document; Continence Procedure Memo, dated August 29, 2024; Interview with DOC, Director of clinical Services, an RPN, an RN, three PSWs, and two Maintenance Staff.

This order must be complied with by February 6, 2025

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

## REVIEW / APPEAL INFORMATION

TAKE NOTICEThe 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.