Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: March 31, 2023	
Inspection Number: 2023-1161-0001	
Inspection Type: Critical Incident System	
Licensee: CVH (No. 3) LP by its general partner, Southbridge Care Homes (a limited partner	
Long Term Care Home and City: Chelsey Park, London	
Lead Inspector Cassandra Aleksic (689)	**Inspector Digital Signature**
Additional Inspector(s) Meagan McGregor (721)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 7, 8, 9, 10, 13, 14 & 15, 2023

The following intake(s) were inspected:

- Intake: #00004025 / CI: 2655-000006-22; and Intake: #00018584 / CI: 2655-000003-23 related to falls prevention and management
- Intake: #00005755 / CI: 2655-000018-22 related to improper/incompetent treatment and plan of care
- Intake: #00019138 / CI: 2655-000004-23 related to prevention of abuse and neglect
- Intake: #00014732 / CI: 2655-000029-22 related to medication management systems

The following intake(s) were completed in this inspection:

- Intake: #00001229 - [CI: 2655-000016-22]; Intake: #00002265 / CI: 2655-000014-22; Intake: #00002481 / CI: 2655-000017-22; Intake: #00002921 / CI: 2655-000025-22; related to falls prevention and management
- Intake: #00015575 / CI: 2655-000031-22; and Intake: #00009003 / CI: 2655-000028-22 related to prevention of abuse and neglect

Inspector Henry Otoo (000753) was also present during this inspection.

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

Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that when a person had reasonable grounds to suspect abuse of a resident had occurred, the incident was immediately reported to the Director.

Rationale and Summary
The Ministry of Long-Term Care received a critical incident report which documented an incident of abuse towards a resident causing risk of harm. The critical incident occurred on a specific date and was not reported immediately to the Director.

The Director of Care (DOC) stated that any suspected, alleged, or actual abuse was to be reported as per mandatory reporting requirements. The DOC stated that the incident was not reported immediately to the Director.

Sources: Critical incident report; Interview with DOC [689]

COMPLIANCE ORDER CO #001 - Medication incidents and adverse drug reactions

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with O. Reg. 246/22, s. 147 (1) (a).

The licensee shall:
A) Ensure that two registered practical nurses review the Medication Incident and Reporting policy, including but not limited to when a medication incident involving a resident or adverse drug reaction occurs, a record of immediate action taken to assess and monitor the resident's health status is documented.
B) Maintain a record of the review, including the staff name, date, and training content.

Grounds
The licensee has failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

A critical incident report was submitted to the Ministry of Long-Term Care which documented that residents in the home were not administered their medications as prescribed due to an internet failure in the home. The home's medication incident report indicated that two registered practical nurses did not provide medications to residents as they did not have a Medication Administration Record (MAR) available. As a result, 27 out of 32 residents had not received their morning medications as prescribed. A resident was identified in the notes as not being administered their medications. As per the resident's plan of care, they were not administered various medications and there were no documented records demonstrating that actions were taken to assess or monitor their health as a result of not being administered the medications.

The home's Medication Incident and Reporting policy, last review January 2022, indicated that residents should be monitored for possible medication-related incident/adverse drug events and that staff should communicate and document medication incident/adverse drug events.

The DOC stated the monitoring of residents for possible medication-related incident or adverse

drug events should have been documented in the progress notes as per the home's medication incident and reporting policy.

Sources: The home's medication incident report and investigative notes, plan of care for residents, and an interview with the DOC [689]

This order must be complied with by May 29, 2023

COMPLIANCE ORDER CO #002 Duty of licensee to comply with plan

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with FLTCA s. 6 (7).

The licensee shall:

A) Develop and implement a process to ensure that all Dietary Aides, Personal Support Workers and any other staff who may serve residents food are made aware of resident food allergies before serving them each meal or snack.
B) Conduct weekly audits of one meal and one snack service to ensure that Dietary Aides, Personal Support Workers and any other staff who may serve residents food are checking for food allergies before serving each resident and that any resident with a documented food allergy is not served food containing that allergen. A documented record of weekly meal and snack service audits must be maintained, which includes the date and time the audit was completed, who conducted the audit, outcome of the audit and any corrective action taken.

Grounds
The licensee has failed to ensure that a resident was not provided food they were allergic to as specified in their plan of care.

Rationale and Summary
A resident's Care Plan indicated they had a specific food allergy and to which they were not to be provided. It was also indicated on their diet profile in the Synergy book located in the dining room that they had a specific allergy. Staff were expected to refer to the diet profile in the

Synergy book to check if residents had any food allergies prior to serving them.

During a meal service, the resident was served the specific food allergen by a Personal Support Worker (PSW). The PSW and a Dietary Aide (DA) did not refer to the Synergy book to check if the resident had any food allergies prior to serving them and did not know the resident had the specific food allergy when they served them a specific food item.

As a result of consuming the food item the resident had an adverse reaction.

Sources: The residents clinical record, including their care plan and progress notes, The Long-Term Care Home's (LTCH) investigation notes related to the incident, and interviews with the PSW and DA, Food Service Manager (FSM) and the Director of Care (DOC) [721]

This order must be complied with by May 29, 2023

COMPLIANCE ORDER CO #003 Food production

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 78 (2) (f)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee has failed to comply with O. Reg. 246/22 s.78 (2) (f)

The licensee shall:
A) Develop and implement a written process for identifying and communicating to Cooks, Dietary Aides, Personal Support Workers and any other staff who may serve residents food which menu items residents can and can not be served due to the presence of food allergens. This process should outline the roles and responsibilities of each staff member in serving the residents food.
B) Provide training to all Cooks, Dietary Aides, Personal Support Workers and any other staff who may serve residents food on the process for identifying and communicating which menu items residents can not be served due to the presence of food allergens. A documented record must be maintained of the training provided, which includes the content of the training, date the training was provided, and who attended the training.

Grounds

The licensee has failed to ensure that the home had a food production system which provided for communication to staff of menu substitutions for a resident with food allergies.

Rationale and Summary
A resident's Care Plan indicated they had a specific food allergy and to which they were not to be provided. It was also indicated on their diet profile in the Synergy book located in the dining room that they had a specific allergy. Staff were expected to refer to the diet profile in the Synergy book to check if residents had any food allergies prior to serving them.

During a meal service, a resident was served a specific food item which contained the food allergen by a Dietary Aide (DA). The DA referred to the Synergy book to check if the resident had any food allergies prior to serving them and knew they had the food allergy, however they did not know the food item contained the food allergen as this had not been communicated to them.

The Food Service Manager (FSM) explained that although there was a process in place for the Cooks and support staff to be notified of food allergens that required menu substitutions, there was a risk in the home with the process.

As a result of consuming the food allergen the resident subsequently had a mild allergic reaction and was treated with good effect. By not having a process in place for communicating the presence of food allergens in menu items to staff there was risk that the resident and other residents in the home with food allergies would be served menu items containing allergens.

Sources: The resident's clinical record, including their care plan and progress notes, The Long-Term Care Home's (LTCH) investigation notes related to the incident, observations of the home's production and serving areas, and interviews with a DA, the FSM and the DOC [721]

This order must be complied with by May 29, 2023

COMPLIANCE ORDER CO #004 Medication Management System

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

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

The Licensee has failed to comply with O. Reg. 246/22, s. 123 (3) (a).

The licensee shall:

A) Ensure that newly hired registered nursing staff, including registered agency nursing staff, are trained on the home's medication administration policies and procedures prior to working in the home, including but not limited to accessing the home's electronic and paper versions of resident Medication Administration Records.
B) Maintain a record of the training including the staff name, date, and training content.

Grounds
The licensee has failed to ensure that home’s medication management policy was implemented by the registered staff.

Rationale and Summary
The Ministry of Long-Term Care received a Critical Incident Report that indicated that there was an internet system failure which impacted morning medication administration to all residents in the home.

The home’s medication incident report indicated that the internet system had failed, and the electronic Medication Administration Record (MAR) was not printed until after the scheduled administration time. The report indicated that a registered nurse (RN) gave medications to five residents which did not follow the medication administration protocol.

The home’s Medication Management policy indicated that registered staff should ensure that the resident information on each medication dispenser (pouch/blister pack/vials etc.) corresponds identically with the resident’s Medication Administration Record (MAR)/ Electronic Medication Administration Record (eMAR) prior to administering the medication. The policy also stated that registered staff should immediately document all medication administered, refused or omitted after administration on the MAR/eMAR using the proper codes.

The Medication Administration Audit Reports for the five residents were reviewed and showed the scheduled medications were documented as administered after a specific time.

The Registered Nurse (RN) stated that they had provided medications to five residents during the internet system failure. The RN stated that they did not have the MAR or eMAR available to reference when administering the medications and had documented the administration in the

eMAR when the internet outage was over. When asked if they had received training related to medication administration, the RN stated that their training did not include how to print the eMAR back up.

The Director of Care (DOC) stated that the RN did not follow the home's medication management policy with regards to ensuring that the medication administered should correspond with the residents MAR/eMAR prior to administration. The DOC stated that the RN should not have provided the medications to the residents if no MAR was available to reference. The DOC stated that the RN who provided medications to the residents was not able to immediately document the medication administration on the eMAR.

Sources: Critical Incident Report; Investigative notes; the home's medication management policy; Medication Administration Audit Reports for five residents, Interview with an RN and the DOC [689]

This order must be complied with by May 29, 2023

COMPLIANCE ORDER CO #005 Administration of Drugs

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with O. Reg. 246/22, s. 140 (2).

The licensee shall:

A) Review and revise the home's process to ensure that in a situation where access to the resident's electronic medication administration records (eMAR) or electronic records system is not available, all residents have timely access to all drugs that have been prescribed to them. A documented record of the review and revision must be maintained and included within the home's medication administration policies and/or procedures.
B) Registered staff, including registered agency staff, are to review the process in part A) to ensure that residents are administered medications as prescribed. The home must maintain a written record of the review which includes who participated in the review, the date the review was conducted, any changes made to improve medication administration, and the date that

those changes were implemented (if any).
C) Develop and document an evaluation of the process developed in Part A) to ensure that home's medication administration policies and/or procedures are followed.

Grounds
The licensee has failed to ensure that medications were administered to residents in accordance with the directions for use specified by the prescriber.

Rationale and Summary
Medication Incident Report was reviewed and documented that the internet system failure occurred, and the electronic Medication Administration Records (eMAR) was not printed until after the scheduled medication administration times. The report indicated that two registered staff members decided not to provide medications to residents.

The home's investigative notes identified that 27 out of 32 residents in the home had not received their medications as prescribed. A resident was identified in the notes as not being administered their medications on the specific date of the internet system failure. The resident was not administered high-risk medications and there were no progress notes which documented if any actions were taken to assess or monitor the residents health as a result of not being administered their medications.

A Registered Practical Nurse (RPN) confirmed that there was an internet outage which affected resident care, specifically medication administration. The RPN stated that medications were not provided to residents as there was no eMAR available. When asked, the RPN stated that the morning medications were not administered to the residents in accordance with the directions for use specified by the prescriber.

The Director of Care (DOC) confirmed that 27 out of 32 residents had not received their medications as prescribed. They stated that not having the MAR available did affect resident care and the ability for staff to complete the medication administration.

Sources: Critical Incident Report; the homes medication incident report and investigative notes; The plan of care for a specific resident; and interviews with an RPN and the DOC [689]

This order must be complied with by May 29, 2023

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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.