Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 9, 2021	2021_792659_0015	005762-21, 006018-21	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 2) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

Long-Term Care Home/Foyer de soins de longue durée

Maitland Manor
290 South Street Goderich ON N7A 4G6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JANETM EVANS (659)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 23, 24, 25 and 28, 2021.

The following intakes were completed during this inspection:
Log #006018-21\Critical Incident System Report (CIS) related to a resident fall with injury.
Log #005762-21\ Follow up to Compliance Order(CO) #001 from inspection #2021_796754_0007, related to medication administration.

Inspector #705751 was present in the home on June 28, 2021, to shadow the inspection.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Environmental Service Manager (ESM), Office Manager, Clerk, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a housekeeper, a screener, residents and a family member.

Observations were completed of medication administration, resident dining, Infection Prevention and Control (IPAC) procedures, the home's air temperature, staff to resident interactions and general care and cleanliness of the home. The following records were reviewed including but not limited to: progress notes, care plans, fall risk assessments, post fall assessments, electronic medication administration records (eMAR), medication incidents, the home's investigation notes, staff training, screening and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that medication was administered to a resident in accordance with directions for use as specified by the prescriber.

Over a two month period, the physician ordered that a resident’s prescribed medication dose be titrated down.

A medication incident involving the resident was identified. The resident's medication dose had been not been decreased as prescribed for 24 days.

The home's investigation found that though the medication order had been transcribed to the resident's electronic Medication Administration Record (eMAR) correctly; the dose dispensed by the pharmacy had not been decreased as per the physician's order. In addition, staff had not ensured the contents of the medication strip matched the eMAR or physician's order prior to administering the medication to the resident.

By not administering the medication as prescribed by the physician, there was potential risk of harm to the resident.

Sources: eMAR, physician’s orders, medication incident form, home's investigation, CNO learning plan, interview with DOC. [s. 131. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that temperatures were taken and documented in every designated cooling area of the home.

Temperature logs between June 12 and June 25, 2021, showed that air temperatures were not taken and recorded in every designated cooling area of the home.

The ESM said the cooling areas in the home included the hallways, the two dining rooms and a lounge. They acknowledged they had not taken and recorded the temperature for every designated cooling area as per the legislation.

Failure to monitor temperatures in all designated cooling areas of the home on a daily basis could result in the home being unaware of elevated temperatures in the home, which could result in risk of harm to the residents.

Sources: Temperature logs June 12-25, 2021, Policy Preventing Heat-Related Illnesses RC-08-01-04, dated June 18, 2021, interview with ESM. [s. 21. (2) 3.]

2. The licensee failed to ensure that the temperatures required to be measured under subsection (2) were documented at least once every morning, once every afternoon between 1200 hours and 1700 hours and once every evening or night.

Between June 12 and June 25, 2021, the home had not measured and recorded temperatures in at least two resident bedrooms in different parts of the home, in one resident common area on every floor, and every designated cooling area in the evening or night.

The ESM said they usually recorded the temperature in the morning and afternoon, before they left the home. They were uncertain if staff were measuring and recording temperatures on evening or night shift.

Failure to measure and document temperatures required under subsection (2) at least once every morning, once every afternoon between 1200 and 1700 hours, and once every evening or night could result in the home being unaware of elevated temperatures in the home, which could result in risk of harm to the residents.

Sources: review of home's temperature logs, Preventing Heat-Related Illnesses RC-08-01-04,dated June 18, 2021, Interview with ESM, staff. [s. 21. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the temperatures required to be measured under subsection (2) are documented at least once every morning, once every afternoon between 1200 and 1700 hours and once every evening or night, including weekends. In addition to this, the licensee will ensure that temperatures are taken and documented in every designated cooling area of the home in accordance with the required frequency of the home as above, to be implemented voluntarily.

Issued on this 26th day of July, 2021

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JANETM EVANS (659)
Inspection No. / No de l'inspection :	2021_792659_0015
Log No. / No de registre :	005762-21, 006018-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 9, 2021
Licensee / Titulaire de permis :	CVH (No. 2) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, Cambridge, ON, N3H-5L8
LTC Home / Foyer de SLD :	Maitland Manor 290 South Street, Goderich, ON, N7A-4G6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tanya Adams

To CVH (No. 2) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2021_796754_0007, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The Licensee must comply with O. Reg. 79/10, s. 131 (2).

Specifically, the licensee must ensure
1. That drugs are administered to the specified resident in accordance with directions for use as specified by the prescriber.
2. That the home will develop and implement audits of the medication administration pass and practice. The audit will include observations of a portion of a medication administration pass on each shift to ensure compliance with the legislation and best practice for medication administration. The audit will be documented, and include the date, the time, the name of the person completing the audit, the name of the registered staff member being audited, any identified areas of concern related to the medication administration, any corrective action taken. The audit will be completed monthly for three months or until the home believes they have achieved compliance with s. 131 (2).

Grounds / Motifs :

1. Compliance order (CO) #001 related to s. 131 (2) from inspection 2021_796754_007 issued on March 3, 2021, with a compliance due date of April 6, 2021, is being re-issued as follows:

The licensee failed to ensure that medication was administered to a resident in accordance with directions for use as specified by the prescriber.

Over a two month period, the physician ordered that a resident's prescribed medication dose be titrated down.

A medication incident involving the resident was identified. The resident's medication dose had been not been decreased as prescribed for 24 days.

The home's investigation found that though the medication order had been transcribed to the resident's electronic Medication Administration Record (eMAR) correctly; the dose dispensed by the pharmacy had not been decreased as per the physician's order. In addition, staff had not ensured the contents of the medication strip matched the eMAR or physician's order prior to administering the medication to the resident.

By not administering the medication as prescribed by the physician, there was potential risk of harm to the resident.

Sources: eMAR, physician's orders, medication incident form, home's investigation, CNO learning plan, interview with DOC. [s. 131. (2)]

An order was made by taking the following factors into account:
Severity: There was risk of harm when the home's registered staff failed to administer drugs as prescribed to the resident.
Scope: The scope of this non-compliance was isolated to one incident.
Compliance History: A compliance order (CO) is being re-issued for the licensee failing to comply with s. 131 (2) of O. Reg 79/10. This subsection was issued as a CO on March 26, 2021, during inspection 2021_796754_007 with a compliance due date of April 6, 2021. Four COs were issued to the home related to different sections of the legislation in the past 36 months. (659)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 20, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 9th day of July, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JanetM Evans

Service Area Office /
Bureau régional de services : Central West Service Area Office