Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 24, 2019	2019_740621_0011	001048-19	Complaint

Licensee/Titulaire de permis

CVH (No. 9) GP Inc. as general partner of CVH (No. 9) LP
766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Southbridge Roseview
99 Shuniah Street THUNDER BAY ON P7A 2Z2

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

JULIE KUORIKOSKI (621)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 9 - 11, 2019.

The following intake was inspected during this Complaint Inspection:
- One intake related to resident rights, medication management, continence care and complaints reporting.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Social Worker (RSW), Resident Assessment Instrument (RAI) Coordinator, Pharmacist Consultant, Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

The Inspector also reviewed relevant health records, as well as licensee policies, procedures and programs specific to continence care, reporting and complaints, medication management and resident rights.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #001 that set out clear directions to staff and others who provided direct care to the resident.

A complaint was received by the Director on a specified date, which identified that the home had not provided a specific type of care consistent with resident #001's care needs.

During an interview with the complainant, they identified to Inspector #621 that resident #001 had required the use of a particular size and type of care product, and had been found during their visits utlizing a care product that was an inappropriate size.

During a review of resident #001's healthcare records, a particular type of assessment was completed on a specific date, which identified the resident was assessed by RPN #105 to require a care product of a certain size and type for a particular medical condition, and that the resident's care plan had been updated.

On review of resident #001's care plan, last revised on a specific date in December 2018, the Inspector found no documentation identifying that resident #001 required the use of a care product for a specific medical condition.

During an interview with PSW #109, they reported that if a resident required a particular

care product for a specific medical condition, they would review the resident's electronic Kardex to determine what the resident's specific care needs were. PSW#109 identified the Kardex reflected what was written in the resident's care plan, as assessed and updated by the registered staff. Further PSW #109 identified that if a resident required the use of a specific care product, that the resident's care plan would identify the need for one, and direct staff to refer to a particular product list kept in a certain location of each unit for further information regarding product specifications.

During an interview with RPN #105, they reported to Inspector #621 that they had completed a particular type of assessment for resident #001 on a day in November 2018, and on review of resident 001's care plan, confirmed that they had not updated the care plan with information from the assessment to identify the need for a specific care product for this resident, and where to find further information specific to the size of and type of product required.

During an interview with the DOC, they reviewed resident #001's care plan, and confirmed that there was no information to identify that resident #001 required specific care product for a certain medical condition, and where to refer for additional information on the specific size and type of care product required. The DOC identified that without this information in the resident's care plan, the plan of care for resident #001, did not provide clear directions to staff providing care to resident #001, with regards to their care product requirements for a specific medical condition. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the provision of care as set out in the plan of care was documented for resident #001.

A complaint was received by the Director on a specific day in January 2019, with concerns regarding resident #001 and failure of the home's staff to notify the substitute decision maker (SDM), following use of a specified type of medically prescribed therapy, on a particular shift, on a specific date in December 2018.

During a review of the resident #001's health record, including prescriber orders, it was identified that on an earlier date in December 2018, an order was initiated by the Nurse Practitioner (NP), with consent of the SDM to use a particular type of therapy for a specified medical condition. A progress note from specific date and time in December 2018, identified that as a result of a specific medical condition, staff administered the prescribed order. On further review of resident #001's health record, it was identified that administration of the prescribed order on a certain date and time in December 2018, was

not documented in a specific section of the resident's plan of care.

During an interview with RPN #104, they reported that administration of medical treatments, including the one specified for use with resident #001 for a certain medical condition, were to be recorded in a specific location within the resident's plan of care.

During an interview with the DOC, they reviewed resident #001's documentation with Inspector #621 and reported that registered staff referred to a particular section of the resident's plan of care to track administration of specific types of orders, as part the management of a specific part of the resident's plan of care. The DOC confirmed that the provision of care which included the administration of a particular order on a specific date and time in December 2018, was not documented as part of a specific record, and should have been. [s. 6. (9) 1.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (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, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, where the LTCHA, 2007 or O. Reg. 79/10 required the licensee of a long-term care home to have a policy and protocols, the policy and protocols were complied with.

In accordance with O.Reg 79/10, r.114(2), the licensee was required to ensure that there were written policies and protocols developed for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration, destruction, and disposal of all drugs used in the home.

A complaint was received by the Director, which identified that during a medication review at a particular meeting on a day in December 2018, it was discovered that a specific medication which the resident had been taking prior to admission, had been missed during the medication reconciliation process. Consequently, the resident had not had the medication, and the error was not discovered until 43 days after admission.

During a review of resident #001's medication reconciliation records, a medication list from the resident's pharmacy service provider to the home on a particular day in November 2018, identified an order for a specific medication type and dose. Comparatively, the home's 'Best Possible Medication History Reconcillation/Admission Orders (Digital)" form, completed by RN #106 on another specific day in November 2018, indicated that the specific medication had been discontinued. There was no further details provided on the form to explain the rationale as to why the medication order was discontinued. Further, Inspector #621 reviewed the resident's electronic health record, including progress notes, and found no documentation from RN #106 or other registered staff, to support the discontinuation of the medication order, or that consent had been obtained by the substitute decision maker (SDM) for discontinuing the medication.

During an interview with the home's consulting Pharmacist, they reported to Inspector #621 that they were present at the specified meeting on a particular day in December 2018, when it was discovered that a specific medication had been missed as part of the medication reconciliation process. The consulting Pharmacist reported that the pharmacy was responsible for filling prescriptions based on orders received by the home, but did not review the orders for accuracy. However, the Pharmacist indicated that since this incident, they had been completing checks for any discontinued medications and were calling the home to confirm the discontinued medication was not a recording error.

During a review of the home's policy as provided by Medical Pharmacies titled "Medication Reconcilliation, 7-2", last updated February 2017, it identified that medication reconciliation was a multidisciplinary process to identify and consolidate the Best Possible Medication History (BPMH) for a resident upon transfer of care (i.e., admission, readmission or discharge), to ensure accuracy and continuity of medication orders and reduce potential adverse events or harm. The policy also identified that the Pharmacist would double check for any discrepancies in the BPMH, with concerns communicated to the nurse and/or physician.

During an interview with RN #106, they reported to Inspector #621 that admissions

tended to be so busy that things could get missed. They identified that the home had a double check process with two RPNs to sign off that the medication reconciliation was completed accurately. They indicated that the Nurse Practitioner (NP) now did the medication reconciliation reviews for the home. RN #106 reviewed resident #001's medication reconciliation record from a specific day in November 2018, and confirmed that it had been completed by them, and that the medication order in question had been checked off as "discontinued", with no further explanation as to why, and that two RPN staff had signed off on the medication reconciliation form.

During an interview with the DOC, they confirmed that the home did not follow their medication reconciliation policy, with RN #106 not checking the accuracy of what they transcribed from resident #001's medication list to the medication reconciliation record, which resulted in an error. The DOC identified that as a result of this incident the home's Pharmacy service provider now did a check, and if there was something checked off as discontinued, they would call the RN on duty to confirm. [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every verbal complaint made to the licensee or a staff member concerning the care of resident #001 was dealt with as follows: 1. The complaint was investigated and resolved where possible, and a response that complied with Ontario Regulation 79/10, s.101(1)3 was provided within 10 business days of the receipt of the complaint.

A complaint was received by the Director on a specific day in January 2019, with concerns regarding resident #001 and management of their care needs, which included concerns that the home failed to provide a response within 10 business days to a verbal complaint that was made by the substitute decision maker (SDM) to the home's Registered Social Worker (RSW), on an earlier specific date in January 2019.

During an interview with the RSW, they reported to Inspector #621 that during communication with resident #001's SDM on the specified date in January 2019, the SDM expressed concerns that they did not receive notification during a particular date and time frame in December 2018, about the need to administer to resident #001, a particular medical order to address a specific medical condition, and consequently, were not prepared for a change in the resident's medical condition later that day.

The RSW reported that at the time of the conversation with the complainant, the complainant identified that they would also be writing a letter to the home. Consequently, the RSW identified that they completed a complaint report form for the verbal complaint as per the home's complaint process, and forwarded a copy to the DOC. The RSW identified that although an internal investigation was completed, the home did not provide a response to the SDM within 10 business days as to what was done to resolve the complaint, or if they determined the complaint to be unfounded, and their reasons for this determination.

Inspector #621 reviewed the home's complaint investigation records for the verbal complaint which included a summary of the complaint lodged, and a report of the investigation completed as of a specific date in January 2019. However, sections of the complaint form that denoted whether the complaint finding was "founded" or "unfounded" and when a written response was forwarded to the complainant, were found blank.

During a review of the home's policy titled 'Complaints and Customer Service - RC-09-01 -04", last updated April 2017, identified the Administrator/designate was responsible for ensuring that timelines for responding to verbal/written complaints were followed; including completion of an investigation within 10 days. As part of the investigation, the policy identified and that a written response was to be provided at the conclusion of the investigation, and shared with the complainant, resident, SDM, family, staff or any other individuals involved.

During an interview with the DOC, they reported to Inspector #621 that they were aware

of the verbal complaint made by resident #001's SDM on a specific date in January 2019, and completed an investigation into the matter. Additionally, the DOC confirmed that they had not provided the SDM with a written response to their verbal complaint within 10 business days, or anytime thereafter. [s. 101. (1) 1.]

Issued on this 29th day of April, 2019

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

Original report signed by the inspector.