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**

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## 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 |
|---|---|---|---|
| Jan 29, 2020 | 2020_740621_0002 | 000747-20 | Other |

### Licensee/Titulaire de permis

CVH (No. 9) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)
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), KATHERINE BARCA (625)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct an Other inspection.**

**This inspection was conducted on the following date(s): January 20 - 22, 2020.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Directors of Care (ADOCs), the Environmental Services Manager (ESM), the Resident Services Coordinator (RSC), a Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Housekeeping Aide, and residents.**

**The Inspector(s) also conducted a tour of the resident care areas, observed resident care, and reviewed the home's supporting documentation, including relevant health care records, as well as specific licensee policies, procedures and programs.**

**The following Inspection Protocols were used during this inspection:**
**Dining Observation**
**Falls Prevention**
**Medication**
**Reporting and Complaints**
**Residents' Council**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
- **5 WN(s)**
- **1 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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 Ontario Regulation (O. Reg.) 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

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

Specifically, staff did not comply with the licensee's policy titled "Shift Change Monitored Drug Count - 6-6", revised November 2018, which was part of the licensee's pharmacy provider's "Pharmacy Policy & Procedure Manual for LTC Homes". The policy identified that "The shift count must be reconciled with the actual amount of drug in the packaging (not just the last blister number or doses). If an individual count is used, the shift count should be reconciled with this as well to account for actual daily use", and that staff were to record the "...client name, medication name and strength on 'Shift Change Monitored Medication Count' form upon receipt of medication."

On a specific date, and at a specified time in January 2020, Inspector #625 observed RPN #110 administer resident #006 a specified medication. The Inspector noted the resident's blister package, contained a pharmacy label that identified the quantity of tablets present, the strength of the tablets, as well dosing and administration times. The RPN signed out resident #006's medication dose on the Monitored Medication Record, for 7-Day Card, (the home's individual resident count record), and recorded the balance after accounting for the administered dose, as a specific quantity; after accounting for the administered dose.

The Inspector reviewed the Unit Narcotic and Controlled Drug Count Sheet, (the shift count form used by the home), to confirm the units of the count, as observed on resident #006's Monitored Medication Record for 7-Day Card. The sheet contained an entry on a specific date and time in January 2020, for resident #006's medication, which did not identify the drug's strength, and recorded a specific count quantity.

Inspector #625 reviewed resident #007's Individual Monitored Medication Record, which identified a specific medication, with a specified quantity and administration schedule. The medication strength was not listed, and the amounts given and quantity remaining, were listed in a specified volume. A second Individual Monitored Medication Record for this resident identified an entry where the name and strength of the medication were not listed, and the amounts given, as well as quantity remaining, were listed as a specified number of capsules.

The Inspector also reviewed resident #008's Monitored Medication Record for 7-Day Card, which included a pharmacy label identifying a specific number of tablets of a specific medication and medication strength were packaged, along with specifications on the dosing and administration frequency for this resident. The document listed the initial quantity from the pharmacy, which was entered by the home's staff as a specific number of partial pieces of medication received. Subsequent entries also identified the balance was the number of partial tablets left. The resident's Unit Narcotic and Controlled Drug Count Sheet did not list the strength of the medication counted, and reflected a number of specific pieces of the medication that were present.

During an interview with RPN #110, they explained that the Unit Narcotic and Controlled Drug Count Sheet, referred to a specific number of individual pieces of resident #006's medication being present, even though some of the pieces of medication were of one specific strength, and some were of a different strength. The RPN identified that the count sheet did not indicate how many tablets of each strength were left, or the total amount of the drug remaining. The RPN stated that the count was done in that manner for all residents in the home, that staff counted the actual number of partial or full tablets present, and recorded that number.

During an interview with ADOC #111, they stated that the home used a shift count form that differed from what the pharmacy provided, and that the Medical Pharmacies policy titled "Shift Change Monitored Drug Count", included a document which identified that the medication strength was to be included in the count record. The ADOC acknowledged

that the entry for resident #006's specific medication, listed on the Unit Narcotic and Controlled Drug Count Sheet, (used by the home as the shift count form), did not include the strength of the resident's medication. The ADOC identified that the strength could not be included in the column entry, as the number counted by staff reflected more than one different medication strength. The ADOC stated that the actual amount of the medication (as identified in a specific metric unit of weight of the medication), was not included, so it was unclear what the remaining amount of the specified medication was. The ADOC acknowledged this also applied to the resident's Monitored Medication Record for 7-Day Card, which did not identify the balance of the specified medication, but listed a combined count, representing more than one different drug strength, on the same card. The ADOC identified that resident #007's Individual Monitored Medication Record for a specified medication, also did not identify the amount of the drug remaining in a specified metric unit of weight, or the strength of the drug, but listed the amount given and the balance, in a specific metric unit of volume of the medication. The ADOC stated that staff should not be recording the amount as a specific metric volume, but that they should instead be recording it in a metric weight. The ADOC reviewed resident #008's Unit Narcotic and Controlled Drug Count Sheet and confirmed that it did not list the strength of the medication counted, but recorded the balance of medication remaining as a number of partial tablets. The ADOC identified that the resident's Monitored Medication Record for 7-Day Card, also counted the balance as a number of partial tablets present.

During an interview with the DOC, they acknowledged that the home's policy titled "Shift Change Monitored Drug Count" indicated that the shift count was to be reconciled with the actual amount of the drug in the packaging, not just the last number or doses left, and that this also applied to the individual count sheets used in the home, so that the two documents could be reconciled, to account for daily use. The DOC also acknowledged the home's policy required staff to record the medication name and strength on the Shift Change Monitored Medication Count form, upon receipt of medication. The DOC indicated that the home did not use the drug count form referred to in the home's policy, but used a document titled "Unit Narcotic and Controlled Drug Count Sheet". The DOC also acknowledged that entries for residents #006 and #008 on the Unit Narcotic and Controlled Drug Count Sheet, did not identify the strength of the drugs, and that it wasn't possible to list a strength for resident #006, as the staff were counting more than one different medication strength in one column entry. The DOC acknowledged the count reflected the number of partial/pieces of a tablet, and that resident #006's entry listed the number of the total pieces of different medication doses, without differentiation. The DOC acknowledged this deviation from the policy in the home's count practice was also done on the resident's Individual Monitored Medication Record for 7-Day Card. The DOC also

acknowledged that staff signed for resident #007's medication in metric volume instead of metric weight, including the quantity remaining; and the strength of the medication was not listed on the sheet, so the administered and remaining amounts of the medication were not reflected. The DOC stated the current practice throughout the home did not include listing of strength [amount] of medications in either count. [s. 8. (1) (b)]

***Additional Required Actions:***

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

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**WN #2: 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. (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. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the care set out in the plan of care for resident #002 and #003 was provided as specified in the plan.

During an inspection of one of the home's required programs, Inspector #621 reviewed the most current care plans with a specific focus, for resident #002 and #003.

a) Inspector #621 reviewed resident #002's care plan with a specific focus, last updated on a particular date in November 2019, which identified strategies including, the use of a safety device, which staff were to ensure was in place and in good working order, and a specific item of furniture was placed in a certain position, with its electric controls disengaged.

During an interview with resident #002 on a particular day in January 2020, they reported to Inspector #621 that they had interventions in place, which included the use of a particular safety device. Resident #002 however, reported that the safety device didn't always work, and thought the staff were maybe turning it off. When the Inspector observed the safety device in a certain location of the home, they identified that the unit was not active, and the safety device did not alarm, upon the resident completing a

specified activity. The Inspector also noted that a specific item of the resident's furniture was not in the required position, when resident #002 was engaged in a specified activity. Further, when the Inspector inquired whether resident #002 knew how to operate the electric controls on the item of furniture, the resident effectively demonstrated use of the controls.

During a subsequent interview with RPN #107, they confirmed to the Inspector that resident #002 was a safety risk for certain incidents, their care plan with a specific focus included use of a specific safety device, and that staff were to ensure that the electric controls on a specified item of furniture were locked out. Together with the Inspector, RPN #107 tested resident #002's safety device and determined that the safety device was not operational, as the unit had been disconnected from its power supply, and the battery backup was not working. Additionally, RPN #107 confirmed that the electric controls on the identified item of furniture, was not locked out at the time of inspection, when the resident was engaged in a specific activity.

On review of resident #002's most current care plan, with a specific focus, RPN #107 confirmed to Inspector #621 that their care plan continued to identify the need for a specific safety device, which staff were to ensure was in place and in good working order; and that the electric controls on the identified item of furniture were to be locked out, with the furniture kept in a certain position. RPN #107 confirmed that at the time of inspection, resident #002 was not provided care as per their plan of care, with respect to use of the specified safety device, as well as disengagement of the specified electrical controls.

b) Inspector #621 reviewed resident #003's most current care plan with a specified focus, last updated in October 2019, which identified strategies including, the use of a particular safety device.

During an interview with RPN #107, they identified that resident #003 was a particular safety risk and was another resident who required a specific safety device. Together with the Inspector, RPN #107 checked resident #003's specified safety device and found it not operational. RPN #107 reported to the Inspector that the specified safety device was to be operational at all times, and the reason for why the safety device was not working was that it had been disconnected from the power supply and the battery back up was not working.

On review of resident #003's most current care plan with a specific focus, RPN #107

verified that the resident required the specified safety device. RPN #107 confirmed to the Inspector, that at the time of inspection, resident #003 was not provided care as per their plan of care, with respect to the use of an operational safety device.

During a subsequent interview with PSW #108 the next day, they reported to Inspector #621 that resident #002 was a particular safety risk; had certain strategies in place, including an electrical device that required its controls to be locked out. Together with the Inspector, PSW #108 checked the specified electrical controls, and found them active and engaged; with resident #002 again able to operate the controls independently.

During an interview with RN #109, they reported that PSW staff were to know the residents in their assignment, check for changes to their residents' care plans on each shift, and verify that care planned strategies were in place, when they completed their hourly monitoring rounds. Further, RN #109 reported that at least one resident care plan was reviewed as part of shift change report, to ensure their currency and accuracy, but confirmed that no auditing was completed by registered staff to ensure that care plan strategies were implemented appropriately and consistent with the resident's plan of care. [s. 6. (7)]

***Additional Required Actions:***

***CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home**

**Specifically failed to comply with the following:**

**s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:**
**2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and

those doors were kept closed and locked when they were not being supervised by staff.

During a tour of the home, Inspector #621 identified the following doors leading to non-residential areas, were unlocked and unsupervised by staff:

a) On the home's third floor, in the Renaissance home area, Inspector #621 observed care cart area door A-363 unlocked and unsupervised. When the Inspector opened the door, an electrical breaker panel and humidifier unit was observed on the wall to the right side.

During an interview with RPN #100 and PSW #101, they confirmed with the Inspector that the door to cart room A-363 was to be locked when unsupervised by staff, and at the time of inspection it was found unlocked and unsupervised. Further RPN #100 reported they had not received any training on what the electrical equipment situated within this room was for, and that it was a safety risk for residents, who could have gained access to the area.

b) Also on the Renaissance home area, Inspector #621 observed equipment storage room A-317 unsupervised and the door to the room propped open with a picture frame. Inside the room, the Inspector observed an assortment of wheelchairs, as well as three electrical breaker panels and electrical charging stations situated along the right wall.

During an interview with RPN #100, they confirmed with the Inspector that they were the RPN on duty; the equipment room door on their assigned unit was propped open with a picture frame and left unsupervised; the room was a restricted access area and to be locked at all times, and inside the room contained three large electric breaker panels and electric charging stations for residents' electric wheelchairs, which posed a safety hazard for residents.

c) On the home's third floor, in the Cheshire home area, Inspector #621 observed kitchen door B-302, which accessed the dishwashing area behind the servery to be unlocked and unsupervised. The door had signage which read "Restricted Area Keep Door Closed".

During an interview with Housekeeping Aide #104, they observed and confirmed with the Inspector that kitchen door B-302 was to be locked at all times, and at the time of inspection was found unlocked and unsupervised.

d) On the home's first floor, in secured home area identified as "Heritage House", Inspector #621 observed care cart door B-127 to have a door that unlocked in spite of the locking mechanism engaged, and was unsupervised at the time of inspection. Inside the care cart room, the Inspector found a container of "Urine-Off" spray solution, with directions on the label to "Avoid contact with eyes, skin and open wounds.", and "If ingested, drink with a large quantity of milk and contact physician". Additionally, an electric panel and humidifier control unit was identified on the wall to the right of the room.

During an interview with RPN #106, they confirmed to Inspector #621 that the door mechanism to care cart room door B-127 was not locking properly, and at the time of inspection this room was unsupervised and accessible to residents. RPN #106 reported that this room was to be locked when unsupervised and that this had been the first time anyone had reported an issue with the door to them.

During an interview with the Environmental Services Manager (ESM), they reported that the electrical panels on third floor were operational in both the equipment room and care cart room; the doors to the equipment room, care cart rooms and kitchen doors off the unit serveries were to be kept closed and locked when unsupervised; and the door to care cart room B-127 was not latching properly, which enabled access to the room by anyone.

During an interview with the Administrator, they reported that it was their expectation that internal doors that were restricted access areas like the care cart rooms, equipment storage and dietary dishwashing areas, were to be locked by staff when unsupervised; and if locking mechanisms were not working, to notify maintenance to remedy immediately. [s. 9. (1) 2.]

***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 all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

**Specifically failed to comply with the following:**

**s. 24. (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:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.**
**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.**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident.**
**4. Misuse or misappropriation of a resident's money.**
**5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse or neglect of a resident by anyone, had occurred, or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

As defined by O. Reg. 79/10, s. 2 (1) (a), "emotional abuse" means, any threatening, insulting, intimidating or humiliating gestures, actions, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgment or infantilization that are performed by anyone other than a resident. Further, s. 5 of O. Reg. 79/10,

defines “Neglect” as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a patter of inaction that jeopardizes the health, safety or well-being of one or more residents.

During an inspection of the home’s internal complaints and reporting process, Inspector #621 reviewed a written complaint dated from October 2019, which reported specific situations involving PSW #114, where resident #010 had felt, threatened, uncomfortable during care, and had concerns with lack of care during specific resident activities.

Inspector #621 reviewed the Long-Term Care Homes reporting website and was unable to locate a mandatory critical incident report submitted by the home, for the written complaint made by this complainant, on the aforementioned date, or anytime thereafter.

A review of the home’s investigation notes, identified that, as part of the investigation process for this complaint, the home interviewed residents #012, #013 and #014 and completed a specific type of abuse audit. Further, when ADOC #111 interviewed PSW #115 on a particular date in November 2019, and asked in their opinion whether the actions of PSW #114 constituted a specific type of abuse, PSW #115 confirmed that, from a resident’s perspective, they were.

During an interview with Resident Services Coordinator #116, they identified abuse audits were completed with resident’s #012, #013 and #014 to determine if any other residents who PSW #114 had been assigned to for care during a particular shift on a certain day in October 2019, had concerns about their treatment by the PSW.

A review of Extendicare’s policy titled “Zero Tolerance of Resident Abuse and Neglect: Response and Reporting – RC-02-01-02”, last updated June 2019, identified that mandatory reporting under the Ontario Long-Term Care Homes Act (LTCHA): Section 24(1), requires a person to make an immediate report to the Director where there is a reasonable suspicion that certain incidents occurred, or may occur, including abuse or neglect of a resident by anyone that resulted in harm or a risk of harm to the resident.

During an interview with the DOC, they confirmed that they had received a complaint email on a specific date in October 2019 from the substitute decision maker (SDM) for resident #010, regarding this resident’s care and treatment by PSW #114; the concerns expressed in the email constituted suspicions of resident abuse and neglect, and the home did not immediately report the suspicions of abuse and neglect of resident #010 to the Director, immediately on the date the email was received, (or anytime thereafter), as

part of the mandatory critical incident system (MCIS) reporting process. [s. 24. (1)]

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**WN #5: 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. (2) The licensee shall ensure that a documented record is kept in the home that includes,**
**(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that a documented record was kept in the home that included: (c) the type of action taken to resolve the complaint, including the date of the action, time frame for actions to be taken, and any follow-up action required.

During an inspection of the home's internal complaints and reporting process, Inspector #621 reviewed a written complaint dated from a specific day in November 2019, which expressed concerns about an altercation that was witnessed by a visitor, between resident #001 and another resident.

On follow-up of the home's investigation notes, Inspector #621 found a letter of response to the complainant, but no record of what action the home took to resolve the complaint, when action was taken, or any follow-up action required.

During an interview with the DOC, they confirmed that they had completed the investigation and follow-up of this complaint, but had not kept a documented record of actions the home took to mitigate further altercations between the identified residents. [s. 101. (2) (c)]

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**Issued on this 11th day of February, 2020**

**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) :** | JULIE KUORIKOSKI (621), KATHERINE BARCA (625) |
| **Inspection No. / No de l’inspection :** | 2020_740621_0002 |
| **Log No. / No de registre :** | 000747-20 |
| **Type of Inspection / Genre d’inspection:** | Other |
| **Report Date(s) / Date(s) du Rapport :** | Jan 29, 2020 |
| **Licensee / Titulaire de permis :** | CVH (No. 9) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.)<br>766 Hespeler Road, Suite 301, CAMBRIDGE, ON, N3H-5L8 |
| **LTC Home / Foyer de SLD :** | Southbridge Roseview<br>99 Shuniah Street, THUNDER BAY, ON, P7A-2Z2 |
| **Name of Administrator / Nom de l’administratrice ou de l’administrateur :** | Joanne Lent |

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

## Ordre(s) de l’inspecteur

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

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

To CVH (No. 9) LP by its general partners, Southbridge Health Care GP Inc. and Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Care Homes Inc.), 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**

**Ordre(s) de l'inspecteur**

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

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

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**Order # / No d'ordre :** 001

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

**Order / Ordre :**

The licensee must be compliant with s. 8. (1) of Ontario Regulation (O. Reg.) 79/10.

Specifically, the licensee must:

(a) Ensure registered nursing staff are compliant with the home's policy "Shift Change Monitored Drug Count - 6-6", as part of the home's medication management system;

b) Provide training to registered nursing staff on completion of shift change monitored drug counts, as per the home's policy; and

c) Complete monthly audits of completed drug counts, to ensure registered nursing staff are compliant with the policy.

**Grounds / Motifs :**

1. 1. The licensee has failed to ensure that, where Ontario Regulation (O. Reg.) 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 114 (2), the licensee was required to have written policies and protocols developed for the medication management system, to ensure the accurate acquisition, dispensing, receipt, storage,

administration, and destruction and disposal of all drugs used in the home.

Specifically, staff did not comply with the licensee's policy titled "Shift Change Monitored Drug Count - 6-6", revised November 2018, which was part of the licensee's pharmacy provider's "Pharmacy Policy & Procedure Manual for LTC Homes". The policy identified that "The shift count must be reconciled with the actual amount of drug in the packaging (not just the last blister number or doses). If an individual count is used, the shift count
should be reconciled with this as well to account for actual daily use", and that staff were to record the "...client name, medication name and strength on 'Shift Change Monitored Medication Count' form upon receipt of medication."

On a specific date, and at a specified time in January 2020, Inspector #625 observed RPN #110 administer resident #006 a specified medication. The Inspector noted the resident's blister package, contained a pharmacy label that identified the quantity of tablets present, the strength of the tablets, as well dosing and administration times. The RPN signed out resident #006's medication dose on the Monitored Medication Record, for 7-Day Card, (the home's individual resident count record), and recorded the balance after accounting for the administered dose, as a specific quantity; after accounting for the administered dose.

The Inspector reviewed the Unit Narcotic and Controlled Drug Count Sheet, (the shift count form used by the home), to confirm the units of the count, as observed on resident #006's Monitored Medication Record for 7-Day Card. The sheet contained an entry on a specific date and time in January 2020, for resident #006's medication, which did not identify the drug's strength, and recorded a specific count quantity.

Inspector #625 reviewed resident #007's Individual Monitored Medication Record, which identified a specific medication, with a specified quantity and administration schedule. The medication strength was not listed, and the amounts given and quantity remaining, were listed in a specified volume. A second Individual Monitored Medication Record for this resident identified an entry where the name and strength of the medication were not listed, and the amounts given, as well as quantity remaining, were listed as a specified number of capsules.

The Inspector also reviewed resident #008's Monitored Medication Record for 7-Day Card, which included a pharmacy label identifying a specific number of tablets of a specific medication and medication strength were packaged, along with specifications on the dosing and administration frequency for this resident. The document listed the initial quantity from the pharmacy, which was entered by the home's staff as a specific number of partial pieces of medication received. Subsequent entries also identified the balance was the number of partial tablets left. The resident's Unit Narcotic and Controlled Drug Count Sheet did not list the strength of the medication counted, and reflected a number of specific pieces of the medication that were present.

During an interview with RPN #110, they explained that the Unit Narcotic and Controlled Drug Count Sheet, referred to a specific number of individual pieces of resident #006's medication being present, even though some of the pieces of medication were of one specific strength, and some were of a different strength. The RPN identified that the count sheet did not indicate how many tablets of each strength were left, or the total amount of the drug remaining. The RPN stated that the count was done in that manner for all residents in the home, that staff counted the actual number of partial or full tablets present, and recorded that number.

During an interview with ADOC #111, they stated that the home used a shift count form that differed from what the pharmacy provided, and that the Medical Pharmacies policy titled "Shift Change Monitored Drug Count", included a document which identified that the medication strength was to be included in the count record. The ADOC acknowledged that the entry for resident #006's specific medication, listed on the Unit Narcotic and Controlled Drug Count Sheet, (used by the home as the shift count form), did not include the strength of the resident's medication. The ADOC identified that the strength could not be included in the column entry, as the number counted by staff reflected more than one different medication strength. The ADOC stated that the actual amount of the medication (as identified in a specific metric unit of weight of the medication), was not included, so it was unclear what the remaining amount of the specified medication was. The ADOC acknowledged this also applied to the resident's Monitored Medication Record for 7-Day Card, which did not identify the balance of the specified medication, but listed a combined count, representing more than

one different drug strength, on the same card. The ADOC identified that resident #007's Individual Monitored Medication Record for a specified medication, also did not identify the amount of the drug remaining in a specified metric unit of weight, or the strength of the drug, but listed the amount given and the balance, in a specific metric unit of volume of the medication. The ADOC stated that staff should not be recording the amount as a specific metric volume, but that they should instead be recording it in a metric weight. The ADOC reviewed resident #008's Unit Narcotic and Controlled Drug Count Sheet and confirmed that it did not list the strength of the medication counted, but recorded the balance of medication remaining as a number of partial tablets. The ADOC identified that the resident's Monitored Medication Record for 7-Day Card, also counted the balance as a number of partial tablets present.

During an interview with the DOC, they acknowledged that the home's policy titled "Shift Change Monitored Drug Count" indicated that the shift count was to be reconciled with the actual amount of the drug in the packaging, not just the last number or doses left, and that this also applied to the individual count sheets used in the home, so that the two documents could be reconciled, to account for daily use. The DOC also acknowledged the home's policy required staff to record the medication name and strength on the Shift Change Monitored Medication Count form, upon receipt of medication. The DOC indicated that the home did not use the drug count form referred to in the home's policy, but used a document titled "Unit Narcotic and Controlled Drug Count Sheet". The DOC also acknowledged that entries for residents #006 and #008 on the Unit Narcotic and Controlled Drug Count Sheet, did not identify the strength of the drugs, and that it wasn't possible to list a strength for resident #006, as the staff were counting more than one different medication strength in one column entry. The DOC acknowledged the count reflected the number of partial/pieces of a tablet, and that resident #006's entry listed the number of the total pieces of different medication doses, without differentiation. The DOC acknowledged this deviation from the policy in the home's count practice was also done on the resident's Individual Monitored Medication Record for 7-Day Card. The DOC also acknowledged that staff signed for resident #007's medication in metric volume instead of metric weight, including the quantity remaining; and the strength of the medication was not listed on the sheet, so the administered and remaining amounts of the medication were not reflected. The DOC stated the current practice throughout the home did not include listing of strength [amount] of

medications in either count. [s. 8. (1) (b)]

The severity of the issue was determined to be a level 2, as there was minimal risk/harm to residents. The scope was a level 3, as a sample of 3 out of 3, or 100 per cent of monitored medication records were non-compliant with the home's policy. The home had a level 3 compliance history, as it had previous non-compliance with the same subsection of Ontario Regulation 79/10, within the previous 36 months, as follows:
- a WN was issued on April 24, 2019, in inspection report #2019_740621_0011. (625)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Mar 20, 2020

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

## Ordre(s) de l'inspecteur

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

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

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**Order # / No d'ordre :** 002

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, 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. 2007, c. 8, s. 6 (7).

**Order / Ordre :**

The licensee must be compliant with s. 6 (7) of the Long-Term Care Homes Act (LTCHA), 2007.

Specifically, the licensee must:

a) Ensure resident #002, #003 and all other residents in the home with active specified care plans, are provided care as per their plans of care; and

b) Implement an auditing process at regular intervals, which is completed by registered nursing staff and/or management staff, to ensure the specified care plans are implemented as specified in the plan. The home is to keep a record of audits completed, including who completed the audit, the date/time of the audit, the name of the resident, details of the specified care plan in place, any variances found, and corrective action taken.

**Grounds / Motifs :**

1. 1. The licensee has failed to ensure that the care set out in the plan of care for resident #002 and #003 was provided as specified in the plan.

During an inspection of one of the home's required programs, Inspector #621 reviewed the most current care plans with a specific focus, for resident #002 and #003.

a) Inspector #621 reviewed resident #002's care plan with a specific focus, last updated on a particular date in November 2019, which identified strategies including, the use of a safety device, which staff were to ensure was in place and in good working order, and a specific item of furniture was placed in a

certain position, with its electric controls disengaged.

During an interview with resident #002 on a particular day in January 2020, they reported to Inspector #621 that they had interventions in place, which included the use of aparticular safety device. Resident #002 however, reported that the safety device didn't always work, and thought the staff were maybe turning it off. When the Inspector observed the safety device in a certain location of the home, they identified that the unit was not active, and the safety device did not alarm, upon the resident completing a specified activity. The Inspector also noted that a specific item of the resident's furniture was not in the required position, when resident #002 was engaged in a specified activity. Further, when the Inspector inquired whether resident #002 knew how to operate the electric controls on the item of furniture, the resident effectively demonstrated use of the controls.

During a subsequent interview with RPN #107, they confirmed to the Inspector that resident #002 was a safety risk for certain incidents, their care plan with a specific focus included use of a specific safety device, and that staff were to ensure that the electric controls on a specified item of furniture were locked out. Together with the Inspector, RPN #107 tested resident #002's safety device and determined that the safety device was not operational, as the unit had been disconnected from its power supply, and the battery backup was not working. Additionally, RPN #107 confirmed that the electric controls on the identified item of furniture, was not locked out at the time of inspection, when the resident was engaged in a specific activity.

On review of resident #002's most current care plan, with a specific focus, RPN #107 confirmed to Inspector #621 that their care plan continued to identify the need for a specific safety device, which staff were to ensure was in place and in good working order; and that the electric controls on the identified item of furniture were to be locked out, with the furniture kept in a certain position. RPN #107 confirmed that at the time of inspection, resident #002 was not provided care as per their plan of care, with respect to use of the specified safety device, as well as disengagement of the specified electrical controls.

b) Inspector #621 reviewed resident #003's most current care plan with a specified focus, last updated in October 2019, which identified strategies including, the use of a particular safety device.

During an interview with RPN #107, they identified that resident #003 was a particular safety risk and was another resident who required a specific safety device. Together with the Inspector, RPN#107 checked resident #003's specified safety device and found it not operational. RPN #107 reported to the Inspector that the specified safety device was to be operational at all times, and the reason for why the safety device was not working was that it had been disconnected from the power supply and the battery back up was not working.

On review of resident #003's most current care plan with a specific focus, RPN #107 verified that the resident required the specified safety device. RPN #107 confirmed to the Inspector, that at the time of inspection, resident #003 was not provided care as per their plan of care, with respect to the use of an operational safety device.

During a subsequent interview with PSW #108 the next day, they reported to Inspector #621 that resident #002 was a particular safety risk; had certain strategies in place, including an electrical device that required its controls to be locked out. Together with the Inspector, PSW#108 checked the specified electrical controls, and found them active and engaged; with resident #002 again able to operate the controls independently.

During an interview with RN #109, they reported that PSW staff were to know the residents in their assignment, check for changes to their residents' care plans on each shift, and verify that care planned strategies were in place, when they completed their hourly monitoring rounds. Further, RN #109 reported that at least one resident care plan was reviewed as part of shift change report, to ensure their currency and accuracy, but confirmed that no auditing was completed by registered staff to ensure that care plan strategies were implemented appropriately and consistent with the resident's plan of care. [s. 6. (7)]

The severity of the issue was determined to be level 3, as there was actual risk to the residents inspected. The scope of the issue was a level 2, as there was a pattern of occurrence present. The home had a level 3 compliance history, as it had previous non-compliance with the same subsection of the Ontario Long-Term Care Homes Act (LTCHA),2007, within the previous 36 months as

follows:
- a VPC was issued on June 28, 2019, in inspection report #2019_703625_0012. (621)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Mar 20, 2020

## 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:

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 29th day of January, 2020**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Julie Kuorikoski

**Service Area Office /**
**Bureau régional de services :** Sudbury Service Area Office