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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Feb 25, 2021	2021_722630_0009	001116-21, 001866-21	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 8) 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

Seaforth Long Term Care Home
100 James Street Seaforth ON N0K 1W0

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

AMIE GIBBS-WARD (630)

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): February 22 and 23, 2021.

The following Critical Incident (CI) intakes were completed within this inspection:

Log #001116-21 / CI 1135-000004-21 related to Infection Prevention and Control (IPAC) and a COVID-19 Outbreak.
Log #001866-21 / CI 1135-000005-21 related to a Medication Incident.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, a Housekeeper, a COVID-19 Entrance Screener and a Registered Practical Nurse (RPN).

The inspector also observed resident rooms and common areas, observed IPAC practices within the home, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed the CI reports and the home's investigation documentation, reviewed COVID-19 Directive #3 and Directive #5 for Long-Term Care Homes and reviewed relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication

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

- **1 WN(s)**
- **1 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was administered to a resident unless the drug had been prescribed for the resident.

A resident was administered medications which were not prescribed for them, as they had been given another resident's medications by mistake. This incident was identified by the management of the home as having caused harm to the resident.

Staff and management in the home reported contributing factors related to this specific medication error. The staff were not following the expected medication administration practices within the home as they did not follow the required practices to ensure the right medications were administered to the right resident using two identifiers. Other contributing factors to the medication error were identified by the staff and management in the home as the heavy staff workload and fatigue associated with the home's COVID-19 outbreak, multiple changes that had occurred with resident room locations and staffing, and unclear expectations related to the role of registered nursing staff on orientation.

Sources: A Critical Incident (CI) report; residents' medication orders and other clinical records; the home's policy titled "The Medication Pass" with revised date January 2018; interview with the Director of Care (DOC) and other staff. [s. 131. (1)]

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 no drug is administered to residents in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

Issued on this 25th day of February, 2021

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

Original report signed by the inspector.