Ontario

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

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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: May 15, 2024
Inspection Number: 2024-1039-0001
Inspection Type: Critical Incident
Licensee: CVH (No. 9) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)
Long Term Care Home and City: Southbridge Lakehead, Thunder Bay

Lead Inspector	**Inspector Digital Signature**
Christopher Amonson (721027)	Christopher E Amonson Digitally signed by Christopher E Amonson Date: 2024.05.16 15:15:30 -04'00'

Additional Inspector(s)

Monica Petti (000876) was present for the inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 6 - 10, 2024

The following intakes were completed during this inspection:

- One intake related to a disease outbreak; and
- Three intakes related to a resident missing more than three hours.

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

Medication Management
Safe and Secure Home
Infection Prevention and Control

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The licensee failed to ensure that drugs were stored in an area or medication cart, that was secured and locked.

Summary and Rationale
Medications were found to be unattended in an unsecured area. Registered staff acknowledged that the medications were left unsupervised. The medications were immediately placed in a secure area.

Additional observations during the course of the inspection noted areas with medications to be secure, and no medications left unattended.

Sources: Inspector observations of all home areas in the LTC home; a policy titled "Medication Storage Areas" last reviewed June 30, 2023; LTC home policy titled "Medication Management" last reviewed March 2023; interviews with staff and DOC.

[721027]

Date Remedy Implemented: May 10, 2024

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 3.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
3. A resident who is missing for three hours or more.

The licensee failed to ensure that the Director was immediately informed of a resident who was missing for three hours or more.

Rationale and Summary
An incident occurred where a resident was determined to be missing for more than three hours. The Executive Director (ED) confirmed that the incident was not immediately reported to the Director.

Sources: A Critical Incident report; a resident's health care records; LTC home's investigation file; LTC home policy titled "Code Yellow - Missing Resident Policy", last reviewed January 2023; and interviews with the ED. [721027]