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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 8, 2021	2021_661683_0008	004642-21, 006852-21, 006853-21, 006854-21	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 1) 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

West Park Health Centre
103 Pelham Road St Catherines ON L2S 1S9

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

LISA BOS (683), LISA VINK (168)

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 17, 18, 21, 22, 23, 24 and 25, 2021.

This inspection was completed concurrently with complaint inspection #2021_661683_0009.

The following intake was completed during this critical incident inspection:
Log #004642-21, CIS #1500-000010-21 was related to medication administration.

The following follow up inspections were completed concurrently with this critical incident inspection:
Log #006852-21 was related to CO #001 from inspection #2021_661683_0003 regarding LTCHA, s. 6 (7);
Log #006853-21 was related to CO #002 from inspection #2021_661683_0003 regarding O. Reg. 79/10, s. 229 (4); and
Log #006854-21 was related to CO #001 from inspection #2021_661683_0004 regarding LTCHA, s. 15 (2).

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Former DOC, Environmental/Food Service Manager, Resident Assessment Instrument (RAI) Coordinator, Nursing Clerk, Registered Dietitian, Maintenance, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, resident and staff interactions, infection prevention and control practices and reviewed clinical health records, relevant home policies and procedures, internal investigation notes, audits, training records, temperature logs, meeting minutes and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Falls Prevention
Infection Prevention and Control
Medication
Safe and Secure Home

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #001	2021_661683_0004	683
O.Reg 79/10 s. 229. (4)	CO #002	2021_661683_0003	683
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2021_661683_0003	683

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. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that clearly indicated when activated where the signal was coming from.

A review of the home's Maintenance Inspection Checklists indicated that when activated, a call bell in a resident common area displayed lights with no sounds. A third-party contractor assessed the call bell system and documented that the call bell in the resident common area rang on the console on another floor in the home.

A maintenance staff member confirmed that the only call bell not working correctly at the time of the inspection was the one in the resident common area which when activated, rang on a different floor in the home. They indicated that the staff were notified of the code on the console to indicate the call bell was ringing from the other floor in the home, and that a third-party contractor was not able to fix the issue.

The Inspector tested the call bell in the identified resident common area and when activated, a light was displayed with no sound. When the Inspector went to the nursing station on another floor, a call bell was sounding, and the console indicated a specific code. A Registered Nurse (RN) and Registered Practical Nurse (RPN) did not know what the code meant. The RPN who was working on the home area with the malfunctioning call bell was unaware that the call bell in a resident common area sounded on a different floor of the home.

The Executive Director (ED) acknowledged that it was not clear where the signal was coming from when the call bell in the resident common area rang on a different floor of the home.

The call bell in the resident common area did not clearly indicate where the signal was coming from which put residents at risk of not receiving assistance in a timely manner.

Sources: Maintenance Inspection Checklists; Reports from a third-party contractor; observations; interviews with RPNs, a RN, a maintenance staff member and the ED. [s. 17. (1) (f)]

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 home is equipped with a resident-staff communication and response system that clearly indicates when activated where the signal is coming from, to be implemented voluntarily.

WN #2: 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 drugs were not used or administered to a resident unless they were prescribed for the resident.

A resident was administered medications which were prescribed for another resident, according to the clinical health records of the co-resident and Critical Incident System (CIS) report.

A RPN self-identified the error later in the same shift, the resident was assessed and their substitute decision maker (SDM) and physician were notified of the incident. The physician ordered that the resident be monitored.

Several days later, the resident was transferred to the hospital, after a change in condition, prior to being readmitted to the home.

The resident was administered medications which were not prescribed for them.

Sources: CIS report; progress notes; electronic Medication Administration Records and interviews with a RPN 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 used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that occurred in the home in order to reduce and prevent medication incidents and adverse drug reactions.

It was identified that the home did not have a Professional Advisory Committee (PAC) meeting in the first quarter of 2020.

A review of the PAC meeting minutes identified under the agenda topic "Pharmacy Updates", medication errors. There was no record of a quarterly review of all medication incident and adverse drug reactions or any change or improvements identified.

Interview with the Director of Care (DOC) identified that to their recall there was a discussion at this meeting regarding the need to review medication incidents and review for trends.

The ED identified that they received a written report from the pharmacy on a monthly basis on all medication incidents; however, they could not comment on additional actions taken with the reports.

The licensee could not demonstrate a record that there was a quarterly review undertaken of all medication incidents and adverse drug reactions that occurred in the home to reduce and prevent medication incidents and adverse drug reactions, or that any changes and improvements identified in the review were implemented.

Sources: PAC meeting minutes and interview with the ED and the DOC. [s. 135. (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 a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, to be implemented voluntarily.

WN #4: 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. Please note the following finding of non-compliance was further evidence to support an order issued on May 4, 2021 (A1), during inspection #2021_661683_0003 (A1) for LTCHA, s.6 (7) related to plan of care, to be complied by May 31, 2021 (A1).

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident, as specified in the plan.

A resident was involved in an incident.
The physician was notified and ordered that the resident was to have an assessment completed at specified intervals.
Interviews with the DOC, a RN and an RPN each confirmed that the assessment required specific checks to be completed.
A review of the clinical record indicated that the resident was assessed, but the specific checks required for the assessment were not completed.

Care was not provided as set out in the plan of care related to the completion of an assessment.

Sources: Progress notes and assessments of a resident and interviews with DOC and the other staff. [s. 6. (7)]

WN #5: 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:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home and in every designated cooling area.

The home's Temperature and Humidity Logs were reviewed. Temperatures were measured three times a day at the first and second floor nursing stations, the staff room in the basement, the kitchen, the physiotherapy room in the basement and the TV lounge on the first and second floors.

A RN confirmed the areas where the temperatures were measured and acknowledged that temperatures were not measured in any resident bedrooms.

The ED acknowledged that the home did not have central air conditioning and indicated that the home's designated cooling areas included the dining rooms and the TV lounges on the first and second floors of the home. They acknowledged that temperatures were not measured in the home's dining rooms as required.

By not measuring the temperatures in resident bedrooms or the designated cooling areas, there was a risk that inappropriate temperatures may not have been identified.

Sources: Temperature and Humidity Logs; interview with a RN and the Executive Director. [s. 21. (2) 1.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. The licensee has failed to comply with Compliance Order (CO) #002 from inspection #2021_661683_0003 served on April 6, 2021, with a compliance due date of May 31, 2021.

The required audits to ensure that appropriate signage was posted outside of all resident rooms who required additional precautions was not developed or fully implemented. The ED provided the Inspector with the home's Infection Prevention and Control (IPAC) audits, but they did not include audits related to signage for residents with additional precautions. The ED was unable to locate any documentation that this step in the order was completed at the time of the inspection.

Sources: CO #002 from Inspection #2021_661683_0003; IPAC audits and interview with the ED. [s. 101. (3)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which included the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

A request was made of the DOC to provide the most recent annual review to evaluate the effectiveness of the medication management system. The DOC provided a Quality Protocol Medication dated May 2019 and an undated Quality Program Evaluated - Medication Annual Evaluation, which was scheduled for March.
The DOC identified that the home did not complete an evaluation in 2020 of the medication management system.

The annual review of the medication management system was not completed as required.

Sources: Quality Protocol Medication and Quality Program Evaluated - Medication Annual Evaluation and interview with the DOC and other staff. [s. 116. (1)]

Issued on this 9th day of July, 2021

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

Original report signed by the inspector.