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
Jan 22, 2020	2020_624196_0001	019436-19, 019518-19, 022264-19	Critical Incident System

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 Pinewood
2625 Walsh Street East THUNDER BAY ON P7E 2E5

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

LAUREN TENHUNEN (196), MELISSA HAMILTON (693)

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): January 6 - 10, 2020.

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:
- One intake related to missing or unaccounted controlled substances;
- One intake related to a missing resident; and
- One intake related to improper/incompetent treatment of several residents.

Follow up inspection #2020_694196_0002 was inspected concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Registered Pharmacist (RPh), Personal Support Workers (PSWs), and residents.

The Inspectors also conducted a daily tour of the resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation files, employee records and relevant licensee policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
2 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. 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, institute or otherwise put in place any policy, protocol or procedure, that the policy, protocol or procedure was complied with, with respect to the medication management system.

In accordance with O. Reg. 79/10, r.114.(1) the licensee was required to ensure that the medication management system was developed and implemented in the home. Specifically, staff did not comply with the licensee's policies regarding Discontinued Medications (Revised 9/19), Drug Destruction and Disposal (Revised 1/19) and Storage of Monitored Medications (Revised 2/17), which were part of the licensee's medication management system.

A Critical Incident System (CIS) report was submitted to the Director on a specific date in 2019, for an alleged incident of missing and or unaccounted controlled substance. The report outlined the details of the incident and the process of the homes' investigation.

The homes' investigation notes were reviewed by Inspector #196. The home's investigation into missing and unaccounted for narcotics had determined a particular concern and that the staff members were non-compliant with the following Medical Pharmacies policies related to Monitored Medications (narcotics and controlled substances):
- Discontinued Medications (section 4, Policy 4-10, Revised 9/19)
- Drug Destruction and Disposal (Section 5, Policy 5-4, Revised 1/19)
- Storage of Monitored Medications (Section 6, Policy 6-4, 2/17).

During an interview with Inspector #196, the DOC confirmed that the three identified staff members had not followed the Medical Pharmacies policies as was required. [s. 8. (1) (b)]

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 that ensures, when a 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, institute or otherwise put in place any policy, protocol or procedure, that the policy, protocol or procedure was complied with, with respect to the medication management system, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to secure outside areas that precluded exit by a resident, including balconies and terraces, were equipped with locks to restrict unsupervised access to those areas by residents.

A Critical Incident System (CIS) report was submitted to the Director on a specific date in 2019, for an incident in which a resident was missing from the home, for a period of time. The CIS report identified that at the time of the incident, the fence of the particular patio area was observed to be missing the lock that was supposed to be in place.

Inspector #693 reviewed the progress notes for resident #006. A progress note from the date of the incident, indicated that the Dietary Aide stated they saw the resident outside of the home and went outside to bring them back. The progress note further identified that staff suspected that the resident went out the particular patio door to a specified outdoor area, and left the grounds of the home through the fence of this patio.

During an interview with PSW #108, they stated the door leading to the particular patio area on the specific unit of the home, was to be locked at all times, and that the fence of this patio area had a padlock which secured it at all times.

During an interview with RN #104, they stated the door leading to the particular patio area on the specific unit of the home, was locked at all times, as well the fence of the area was locked at all times. The RN identified that during the summer months and warm weather, residents could use the patio, with the supervision of recreation staff or family members.

Inspector #693 reviewed the home's investigation notes. The notes identified that the patio door was unlocked and the back gate did not have a padlock in place.

Inspector #693 reviewed the home's policy, titled, "Door Surveillance and Secure Outdoor Area, OP-04-01-04", last updated in December, 2019. The policy indicated that doors leading to secured outdoor areas and balconies were to be equipped with a locking system and be locked during time frames specified by the home.

During an interview with the Executive Director (ED), they stated the door leading to the particular patio area, on the specific unit, was to be locked at all times during the winter months and unlocked in the summer months during daytime hours, as well that the fence of this patio area was to be locked at all times. The ED stated that residents were able to go into the particular patio area on their own, as the RPN was responsible for completing hourly checks, and that residents were only allowed to be in the particular patio area when supervised by staff or family members. The ED indicated that the home identified that on the date of the incident, the door leading to this outdoor area was unlocked, when

resident #006 eloped from the home, and the fence of the particular patio area was not locked as it should have been, so the resident was able to leave the grounds of the home. [s. 9. (1) 1.1.]

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 that ensures all doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, were equipped with locks to restrict unsupervised access to those areas by residents, to be implemented voluntarily.

Issued on this 22nd day of January, 2020

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

Original report signed by the inspector.