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
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Original Public Report

Report Issue Date: August 15, 2024

Inspection Number: 2024-1445-0002

Inspection Type:
Complaint
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 Pinewood, Thunder Bay

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 3-5, 2024

The following intake(s) were inspected:

- Intake: #00105636 - Enteric Outbreak.
- Intake: #00107842 - Complaint concerns regarding medication administration.
- Intake: #00117447 - Complaint concerns regarding alleged improper care and neglect of resident and cleanliness.
- Intake: #00117855 - Alleged physical abuse of resident by resident.
- Intake: #00118965 - Enteric Outbreak.

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: When reassessment, revision is required

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

Plan of care

s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee had failed to ensure that a resident was reassessed and the plan of care reviewed and revised when, the resident's care needs changed or care set out in the plan is no longer necessary.

Rationale and Summary

A resident's care plan indicated that the resident requires a specified item to be used.

Observations were made of a resident without the use of the specified item.

Interviews with staff confirmed that the identified resident does not typically use the specified item.

An interview with the DOC confirmed that a resident's care plan should be

reassessed to reflect the resident's current care needs.

Sources: Observations; Review of a complaint received by the Director; Review of a resident's care plan; and interviews with staff, and the DOC.

WRITTEN NOTIFICATION: Housekeeping

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (ii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

The licensee has failed to ensure that cleaning and disinfection of supplies and devices are in accordance with manufacturer's specifications.

Rationale and Summary
Observations made within the home identified expired disinfectant located on all resident home areas.

Interviews with the IPAC Regional Coordinator and the home's Administrator confirmed that expired disinfectant should not be used within the home.

Sources: Observations; and interviews with IPAC Regional Coordinator, and Administrator.

WRITTEN NOTIFICATION: Administration of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Rationale and Summary
An RPN demonstrated a medication pass which began one and a half hours prior to the scheduled time as prescribed for a resident.

An RPN confirmed that drugs can be administered within one hour before or after the prescribed time, and earlier administration was not consistent with the home's policies and procedures.

There is a minimal risk associated with the administration of the identified resident's drugs outside of the prescriber's directions.

Sources: Observations; Review of a Complaint related to medication administration; Interviews with registered staff and the DOC; and review of home policy titled The Medication Pass (No. 5.6).

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (6)

Administration of drugs

s. 140 (6) The licensee shall ensure that no resident administers a drug to themself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 246/22, s. 140 (6).

The licensee has failed to ensure that no resident administers a drug to themself unless the administration has been approved by the prescriber in consultation with the resident.

Rationale and Summary

An RPN was observed dispensing and leaving drugs for a resident in their room to administer themselves.

An RPN confirmed that this practice was not consistent with the home's policies and procedures for medication administration.

Sources: Observations; Review of a Complaint received by the Director; Interviews with registered staff and the DOC; and review of home policy titled The Medication Pass (No. 5.).