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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: December 22, 2023
Inspection Number: 2023-1703-0005
Inspection Type: Complaint Follow up
Licensee: CVH (No. 3) 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 Owen Sound, Owen Sound

Lead Inspector	Inspector Digital Signature
Katy Harrison (766)	Kathryn Harrison Digitally signed by Kathryn Harrison Date: 2023.12.27 11:58:40 -05'00'

Additional Inspector(s)
Kailee Bercowski (000734)
Gurvarinder Brar (000687)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 5-8, 12-15, 18, 2023
The inspection occurred offsite on the following date(s): December 18, 2023

The following intake(s) were inspected:
- Intake: #00100062 - IL-18970-CW - Complaint related to continence care
- Intake: #00100224 - Complaint related to multiple concerns
- Intake: #00100462 - IL-19159-CW - Complaint related to falls and nutritional care
- Intake: #00100656 - IL-19265-CW - Complaint related to multiple concerns
- Intake: #00100902 - IL-19373-CW - Complainant related to care
- Intake: #00101553 - Follow-up #: 1 - FLTCA, 2021 - s. 28 (1) 1.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #003 from Inspection #2023-1703-0004 related to FLTCA, 2021, s. 28 (1) 1. inspected by Katy Harrison (766)

The following Inspection Protocols were used during this inspection:

Continence Care
Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 74 (2) (c)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(c) the implementation of interventions to mitigate and manage those risks;

The licensee has failed to ensure the implementation of interventions to mitigate and manage nutritional risks for resident #001.

In accordance with Ontario Regulation 246/22, s.11 (1) b, the licensee was required to ensure that any plan, policy, protocol, program, procedure, strategy, initiative or system was complied with.

As per Snack/Nourishment Policy NC-04-01-10, last reviewed in March 2023, staff are to ensure residents receive assistance during snack service, and special labelled items are not served to residents who require assistance until someone is available to provide the assistance.

As per Meal Service and Dining Experience policy NC-03-01-01, last reviewed on January 2022, staff are to ensure resident diet needs and preferences are accommodated during meal service.

Rationale
A complaint was received indicating a resident had lost significant weight since admission, and staff had not been assisting the resident with eating snacks.

The resident had been assessed to have inadequate energy intake in March. Their plan of care included extensive assistance from one person with eating snacks between meals, and for staff to serve the resident small portions at mealtime.

A) At the time of inspection, the resident was observed to not receive assistance with their snacks on the first two consecutive days of observation. Their labelled snacks were unopened in their room over seven hours later. The resident's intake had been documented for those snacks as 51-100% consumed. When interviewed,

day shift staff were not aware the resident required extensive assistance with eating or opening their snacks or thought another staff would assist the resident with eating.

B) In July, the RD documented observing staff provide the resident a full lunch portion, despite their plan of care including a half entree portion. At the time of inspection, the resident was also observed to receive full portions at four separate meals. Dietary staff said small portions should have included half portions of entrees.

When the resident's dietary interventions were not implemented, they were at risk for additional weight loss.

Sources: Observations; Resident clinical records, Snack / Nourishment Policy NC-04-01-10 & Meal Service and Dining Experience policy NC-03-01-01; Interviews with Registered Dietician / Food Service Supervisor (RD) / FSS and others. [000734]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 147 (1)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician or the registered nurse in the extended class attending the resident and, if applicable, the prescriber of the drug and the pharmacy service provider. O. Reg. 66/23, s. 30.

The licensee failed to ensure a medication incident involving a resident was documented and reported.

The definitions of Ontario Regulation 246/22 include a "medication incident" as a preventable event associated with the prescribing, ordering, or administering of a drug, the monitoring of the use of the drug by the resident, or the transcribing of a prescription. It also includes an act of omission or commission, whether or not it results in harm, injury, or death to a resident.

Rationale
During a nine day period a resident did not receive fourteen doses of their routine medication prescription.

The DOC and ADOC said that would have been considered a medication incident, and confirmed at time of inspection that they had not received a medication incident notification for the situation.

A RN identified the issue, and restarted the medication, but did not report it as a medication incident. No notification of the physician or assessment of the resident related to the incident was documented.

When the medication incident was not documented or reported as a medication incident, the home was unable to respond with an internal investigation, and a

focused assessment of the resident was not completed at the time of medication omission.

Sources: Resident clinical records, as well as interviews with Director of Care (DOC) and staff.
[000734]

COMPLIANCE ORDER CO #001 Administration of drugs

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with s. 140 (2) of Ontario Regulation 242 / 22 for two residents.

The licensee shall:

a) Ensure that registered nursing staff from the unit, as well as two RN's, review the home's process for transcription of orders, including the following elements:

i) How to ensure the pharmacy has received the order, and the responsibilities for nursing staff if the order is not received.
ii) How to transcribe an order that requires a temporary change of dosage.

iii) How to identify a medication incident, and the responsibilities for nursing staff if a medication incident is identified.

b) Develop and implement an auditing process to monitor transcription and ordering of medications for one week, ensuring medications are transcribed and ordered at times prescribed. Keep a documented record of the audits including: the date completed, who completed the audits, the results of the audits, and the follow up with nursing staff. At least one audit of each of the five units within the home must be completed prior to the compliance due date.

C) Keep a documented record of the review which includes who participated in the review, the date the review was conducted, the content of what was reviewed, any changes made to the home's process for transcribing orders, and the date that those changes were implemented (if any).

Grounds
Non-Compliance with O. Reg, 2021, s. 140 (2) related to Administration of drugs

A) The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale
A resident had an infection. The RN received a phone order from the physician for treatment of the infection.

The resident received the first dose of the medication two days later.

The ADOC indicated that the medication was not administered as prescribed when there was a delay of two days for the first dose. They stated that the nurse was

expected to call the on-call pharmacist and collaborate with satellite pharmacy to receive the medication as soon as possible.

The resident's treatment for infection was delayed when the staff failed to follow up with the after-hours pharmacy. The delay in treatment put them at risk of worsening infection.

Sources: Resident clinical records including progress note, electronic medication administration record and prescriber order form. Interviews with a Registered Nurse (RN) and Assistant Director of Care (ADOC)
[000687]

B) The licensee failed to ensure drugs were administered to a resident in accordance with directions for use as specified by the prescriber.

Rationale
A complaint was received indicating a resident had not received a particular medication for a week, which was identified when the resident was observed to have worsening symptoms.

The resident had a routine prescription for the medication.

They were prescribed a new medication treatment for a period of seven days, and the physician ordered the resident's other medication to be reduced in half for the duration of this treatment, as per the pharmacy's suggestion. When the RN transcribed the order, however, they did not include restarting the regular dose of routine medication once the new course of medication was completed.

When the temporary period concluded the resident did not receive any of their

routine medication for seven days. They missed a total of fourteen doses. A RN restarted the routine medication order in the MAR after identifying it was missing. The RN transcribed the original order change and initiated a new routine medication order.

When the resident was not administered their medication as prescribed, they experienced increased symptoms.

Sources: Resident clinical records, as well as Interviews with anonymous complainant, and staff.
[000734]

This order must be complied with by January 31, 2024

REVIEW / APPEAL INFORMATION

TAKE NOTICEThe Licensee has the right to request a review by the Director of this (these) Order(s) and / or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c / o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and / or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.