Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 14, 2015	2015_281542_0013	015163-15, 016982-15, 014637-15, 018712-15	Complaint

Licensee/Titulaire de permis

AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC.
130 ELM STREET SUDBURY ON P3C 1T6

Long-Term Care Home/Foyer de soins de longue durée

CEDARWOOD LODGE
860 GREAT NORTHERN ROAD SAULT STE. MARIE ON P6A 5K7

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

JENNIFER LAURICELLA (542)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 27-31, 2015

During the course of the inspection, the inspector(s) spoke with the Vice President of Management Services for Sienna Senior Living, the Administrator/Director of Care, Registered Staff, Personal Support Workers (PSW's), Director of Support Services, Residents and Family Members

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Medication
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 VPC(s)**
- **1 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	Legendé 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. 131. Administration of drugs

Findings/Faits saillants :

1. The licensee has failed 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.

Inspector #542 completed a review of the medication incident reports that were recorded by the home over a month period. The Administrator/Director of Care informed this Inspector that they have not had the time to follow up with all of the medication incidents

and that some of them are incomplete. It was noted that the home documented 16 medication errors that occurred during one month.

The medication incident reports revealed that resident #005 received the 08:00 medications that were prescribed to resident #012.

Another medication incident report indicated that resident #006 had a physician's order to place one of their medications on hold due to their blood work results. It was noted by the pharmacist that the staff continued to administer the medication even though it should have been held. Therefore the medication was administered to the resident for 4 days without a physician's order.

Resident #003 was administered the wrong antibiotic by S#103.

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

The medication incident reports also revealed that resident #001 did not have their narcotic pain medication provided as there was none available and resident #007 did not receive their pain medication at 17:00 due to a nurse's omission.

Inspector #542 noted that on another day, resident #008 did not receive their medication at 20:00 due to a nurse's omission. Also on the same day resident #009 did not receive 7 of their medications at 20:00 that were ordered by a physician.

During another day, resident #013 did not receive their narcotic pain medication as none was available.

On another day a resident received an extra dose of their narcotic pain medication. There was no indication whether the physician or resident/SDM was notified according to the medication incident report.

It was also documented on the medication incident reports, that the following three resident's did not receive their scheduled 22:00 medications due to a nurse's omission. Resident #011 did not receive one of their 22:00 medications, resident #012 did not receive their 22:00 medication and resident #013 did not have one of their medications removed at 22:00.

Resident #004 was provided with the wrong dosage of a medication and in fact received a stronger dose of that medication due to a nurse's error.

On July 31, 2015, Inspector #542 reviewed the home's Medication policy #PHM-020 titled "Medication System Improvement."
The Policy defines medication incidents as "preventable events associated with the prescribing, transcribing, dispensing and/or administration and distribution of medication. Some can be further classified into incidents of omission or incidents of commission (giving the wrong medication)."

As per the policy the RN/RPN will ensure the accuracy of the medication administration by following the 8 rights:
- The right medication
- The right dose
- The right route
- The right resident
- The right time
- The right expiration date
- The right documentation
- The right of the resident to refuse

The policy further indicates that following a resident-involved incident, the RN/RPN is to notify the physician once the incident is identified or is believed to have occurred, determine how long the resident should be monitored for (e.g. vital signs) and any required treatment that is necessary with input from the physician/pharmacist, and notify the resident/SDM. [s. 131.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. The licensee has failed to ensure that the care set out in the plan of care is provided to resident #002 as specified in the plan.

Inspector completed a health care record review for resident #002 and noted that the physician's order indicated that the resident's wound dressing was to be changed daily with specific interventions. Inspector reviewed the progress notes which indicated that on 6 separate days during a one month period the staff did not have all of the ordered supplies to complete the wound dressing as ordered by the physician. The progress notes revealed that the registered staff were using a different intervention that was not ordered by a physician to complete the wound dressing change. Inspector spoke with the Administrator/Director of Care and asked if the physician was informed that the home did not have the correct wound care supplies in order to complete the wound dressing. The Administrator/Director of Care stated that they did not believe that the physician was notified. On July 28, 2015, Inspector #542 observed S#100 complete the wound dressing change on resident #002. It was noted that S#100 did not have all of the supplies to complete the wound dressing as ordered by the physician. [s. 6. (7)]

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 care set out in the plan of care is provided to resident #002 as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 46. Every licensee of a long-term care home shall ensure that every member of the staff who performs duties in the capacity of registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the College of Nurses of Ontario. O. Reg. 79/10, s. 46.

Findings/Faits saillants :

1. The licensee has failed to ensure that every registered nursing staff (registered nurse, registered practical nurse, registered nurse in the extended class) have the appropriate current certificate of registration with the College of Nurses of Ontario.

Inspector #542 was informed by a complainant that the home had a staff member administering medications to the residents and that this staff member did not have a certificate of registration with the College of Nurses of Ontario. Inspector #542 spoke with the Administrator/Director of Care, who confirmed that the staff member was in fact administering medications under the supervision of herself and other registered staff members however they did not have a certificate of registration. Inspector #542 spoke to S#101 who also confirmed that the staff member was administering medications also while under their supervision. [s. 46.]

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 every registered nursing staff have the appropriate current certificate of registration with the College of Nurses of Ontario, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that equipment, supplies, devices and positioning aids are readily available as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

Inspector #542 completed a health care record review for resident #002. A physician's order for the resident's wound dressing indicated specific interventions to be completed daily. The progress notes revealed that on 6 separate days during a one month period, staff did not have all of the ordered supplies to complete the wound dressing as ordered by the physician. Inspector #542 spoke with the Administrator/Director of Care who confirmed that they were unable to obtain all of the supplies. Inspector also asked if they contacted the physician to inform them that they did not have the required supplies. The Administrator/Director of Care stated that they did not believe anyone called the physician as the order is still the same. On July 28, 2015, Inspector #542 observed S#100 complete the wound dressing and noted that they did not have all of the supplies to complete the wound dressing as ordered by the physician. [s. 50. (2) (c)]

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 equipment, supplies, devices and positioning aids are readily available as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written staffing plan includes a back-up plan for nursing and personal care staffing that addresses situation when staff cannot come to work, including 24/7 RN coverage.

On July 31, 2015, Inspector #542 interviewed the Administrator/ Director of Care who confirmed that the home does not currently have a written staffing plan that includes a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work. [s. 31. (3)]

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 14th day of August, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER LAURICELLA (542)
Inspection No. / No de l'inspection :	2015_281542_0013
Log No. / Registre no:	015163-15, 016982-15, 014637-15, 018712-15
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 14, 2015
Licensee / Titulaire de permis :	AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC. 130 ELM STREET, SUDBURY, ON, P3C-1T6
LTC Home / Foyer de SLD :	CEDARWOOD LODGE 860 GREAT NORTHERN ROAD, SAULT STE. MARIE, ON, P6A-5K7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Silver

To AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Ontario

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Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. Administration of drugs

Order / Ordre :

The licensee shall prepare, submit and implement a plan for ensuring that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident and that all drugs are administered to residents in accordance with the directions for use specified by the prescriber.

The following shall be included in the plan:

1) Training for all registered staff on the home's policy "Medication System Improvement" including how this will be completed.

2) A process for auditing to ensure that all medication incidents are completed, and the steps in the policy are followed.

The plan shall also include time frames for development and implementation and identification of the staff member (s) responsible for the implementation.

This plan shall be submitted in writing to Jennifer Lauricella, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5
Email: jennifer.lauricella@ontario.ca

The plan must be submitted by August 21, 2015 and fully implemented by August 28,
2015.

Grounds / Motifs :

1. 1. The licensee has failed 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.

Inspector #542 completed a review of the medication incident reports that were recorded by the home over a month period. The Administrator/Director of Care informed this Inspector that they have not had the time to follow up with all of the medication incidents and that some of them are incomplete. It was noted that the home documented 16 medication errors that occurred during one month.

The medication incident reports revealed that resident #005 received the 08:00 medications that were prescribed to resident #012.

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three resident's did not receive their scheduled 22:00 medications due to a nurse's omission. Resident #011 did not receive one of their 22:00 medications, resident #012 did not receive their 22:00 medication and resident #013 did not have one of their medications removed at 22:00.

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- The right documentation
- The right of the resident to refuse

The policy further indicates that following a resident-involved incident, the RN/RPN is to notify the physician once the incident is identified or is believed to have occurred, determine how long the resident should be monitored for (e.g. vital signs) and any required treatment that is necessary with input from the physician/pharmacist, and notify the resident/SDM. [s. 131.] (542)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 28, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 14th day of August, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Lauricella

Service Area Office /
Bureau régional de services : Sudbury Service Area Office