



**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
Facsimile: (705) 564-3133

Bureau régional de services de
Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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
Dec 15, 2015	2015_281542_0022	021987-15	Follow up

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



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The purpose of this inspection was to conduct a Follow up inspection.

**This inspection was conducted on the following date(s): October 30, 2015,
November 2, 3, 4, 5, 2015.**

**The inspection was completed in order to follow-up on an order issued to the home
from an inspection conducted in November 2015.**

**During the course of the inspection, the inspector(s) spoke with the Executive
Director/Administrator, the Acting Director of Care, Registered Staff, Personal
Support Workers (PSW), RAI Coordinator and Residents.**

**The Inspector reviewed various policies and procedures of the home, the
medication incidents, training records and various employee human resource files.**

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

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

0 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :



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

During a previous inspection, # 2015_281542_0013, a compliance order was issued for s.131.

Inspector #542 completed a review of the home's medication incident reports for September 2015 and October 2015.

It was documented that in September, seven medication errors were made. Of these seven, five were omissions by the nurse, indicating that the resident did not receive their ordered medications. Two residents were administered the wrong doses of their medications.

During the month of October, nine medication errors were made, six were omissions indicating that the resident did not receive their ordered medications.

The medication incident reports revealed that two residents did not have medication reconciliation completed for them on admission by the physician. Additionally the incident reports showed that one resident received the wrong anticoagulant dosage.

Inspector #542 completed a review of the training records that were provided by the Acting Director of Care. It was noted that eight out of 16 registered staff documented that they had completed the training on the home's policy titled "Medication System Improvement." Therefore eight of the registered staff had not completed the required training as previously issued in a compliance order. All eight of the registered staff that did not receive the training on the home's policy worked in the home administering medications on numerous occasions up to this date.

Inspector #542 met with the Acting Director of Care who also verified that none of the agency registered staff received the training on the home's policy.

The decision to re-issue this compliance order was based on the severity which indicates a potential for actual harm to the residents of the long-term care home. The scope represented that there was a pattern of medication errors and the home has a previous compliance order related to this area. [s. 131. (2)]



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Additional Required Actions:

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

Issued on this 15th day of December, 2015

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

Original report signed by the inspector.



**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

**Ministère 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

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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_0022

Log No. /

Registre no: 021987-15

Type of Inspection /

Genre

d'inspection:

Follow up

Report Date(s) /

Date(s) du Rapport : Dec 15, 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 Liska

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



**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
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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)

Linked to Existing Order /
Lien vers ordre 2015_281542_0013, CO #001;
existant:

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for ensuring that all drugs are administered to residents in accordance with the directions for use specified by the prescriber.

The plan shall include how the home will ensure that all staff who administer medications are provided with training on the home's policies and procedures with regards to medication administration and incidents. The plan shall also include how the home will ensure that an effective and thorough analysis of the Medication Incidents are conducted and by whom. The plan shall also ensure that all residents who are admitted to the home receive a medication reconciliation at the time of admission.

Please submit the plan 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, by email at jennifer.lauricella@ontario.ca, by December 22, 2015.

Grounds / Motifs :

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

During a previous inspection, # 2015_281542_0013, a compliance order was issued for s.131.

Inspector #542 completed a review of the home's medication incident reports for September 2015 and October 2015.

It was documented that in September, seven medication errors were made. Of these seven, five were omissions by the nurse, indicating that the resident did not receive their ordered medications. Two residents were administered the wrong doses of their medications.

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The medication incident reports revealed that two residents did not have medication reconciliation completed for them on admission by the physician. Additionally the incident reports showed that one resident received the wrong anticoagulant dosage.

Inspector #542 completed a review of the training records that were provided by the Acting Director of Care. It was noted that eight out of 16 registered staff documented that they had completed the training on the home's policy titled "Medication System Improvement." Therefore eight of the registered staff had not completed the required training as previously issued in a compliance order. All eight of the registered staff that did not receive the training on the home's policy worked in the home administering medications on numerous occasions up to this date.

Inspector #542 met with the Acting Director of Care who also verified that none of the agency registered staff received the training on the home's policy.

The decision to re-issue this compliance order was based on the severity which indicates a potential for actual harm to the residents of the long-term care home. The scope represented that there was a pattern of medication errors and the home has a previous compliance order related to this area.

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**Ministry of Health and
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de l'article 154 de la *Loi de 2007 sur les foyers
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This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2015



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Pursuant to section 153 and/or
section 154 of the *Long-Term Care
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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



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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.



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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.



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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 15th day of December, 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