Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date June 14, 2022
Inspection Number 2022_1393_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Henley House Limited

Long-Term Care Home and City
The Henley House
20 Ernest Street, St Catherines, ON, L2N 7T2

Inspector Digital Signature

Lisa Vink #168

Additional Inspector(s)
Lesley Edwards #506
Kwesi Douglas #736409
Aileen Graba #682

Lisa Vink Digitally signed by Lisa Vink
Date: 2022.06.29 12:31:57 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 2, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 24, 25, 26, 27, 30, 31, 2022 and June 1, 2022.

The following intake(s) were inspected:

- Log 008223-22, for Critical Incident System (CIS) report number 2909-000031-22 related to safe storage of drugs.
- Log 005206-22, for CIS 2909-000025-22 related to falls prevention and management.
- Log 008771-22, for CIS 2909-000035-22 related to plan of care.
- Log 005979-22, for a complaint related to falls prevention and management.
- Log 009149-22, for a complaint related to nursing and personal support services.
- Log 008183-22, for a complaint related to bathing.

Inspector Adiilah Heenaye Sumser #691990 participated in a portion of this inspection as an observer.

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

- Continence Care
- Falls Prevention and Management
- Food, Nutrition and Hydration
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Medication Management
- Reporting and Complaints
- Resident Care and Support Services
- Responsive Behaviours
- Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

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

Non-compliance with: LTCHA 2007, *s. 6 (1) (a)*

A. The licensee failed to ensure there was a written plan of care for a resident that set out the planned care for the resident related to their fall prevention interventions.

Rationale and Summary
A resident sustained a fall in March 2022.
A progress note identified two new fall prevention strategies were implemented post fall.
The interventions were not included in the care plan.
Observations of the resident confirmed the interventions were in place; however, were not set out in the written care plan where all staff were able to access the information.
Failure to include all planned care in the plan of care had the potential for staff to be unaware of the care needs of the resident.

Sources: Review of progress notes and care plan for a resident, observation of the resident and interview with staff. [506]

Non-compliance with: FLTCA, 2021, *s. 6 (1) (a)*

B. The licensee failed to ensure there was a written plan of care for a resident that set out the planned care.

Rationale and Summary
A resident's progress notes identified the responsive behaviours of a co-resident caused them distress.

An intervention was initiated in response.
Observations of resident's environment included the intervention; however, it was not engaged.
The clinical record did not identify the intervention or provide any direction when to engage the strategy.
By staff not including the intervention in the written plan of care the resident was at risk for not having their needs met.

Sources: Complaint log, a resident's clinical record, observations of the resident, and interview with staff. [682]

WRITTEN NOTIFICATION: INVOLVEMENT OF THE RESIDENT ETC.

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, *s. 6 (5)*

A. The licensee failed to ensure that the Substitute Decision Makers (SDMs) of a resident were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary
An SDM identified they were not notified when the resident sustained a fall.
The clinical record confirmed the resident fell and the SDMs were not notified.
Failure to notify the SDM of the fall resulted in lack of participation in the resident's plan of care.

Sources: A resident's clinical record and interview with staff. [506]

Non-compliance with: LTCHA, 2007, *s. 6 (5)*

B. The licensee failed to ensure that the SDM of a resident was given an opportunity to participate fully in the implementation of the plan of care, related to refusal of the consent to a drug.

Rationale and Summary
A resident's record in Point Click Care (PCC) noted their SDM refused to consent to a drug, on behalf of the resident.
A review of a consent form identified their SDM did not consent to a drug.
The consent form included documentation that the resident was administered the drug after consent was withheld.
Failure to include the SDM in the implementation of the plan of care resulted in the administration of a drug that was not consented to on behalf of the resident.

Sources: Clinical health record of a resident and interviews with staff. [168]

WRITTEN NOTIFICATION: DUTY OF THE LICENSEE TO COMPLY WITH THE PLAN OF CARE

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 6 (7)

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA.
As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 6 (7) of LTCHA.

A. The licensee failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan related to an assessment.

Rationale and Summary

A resident's clinical record identified they had an order written in June 2021, to have an assessment completed twice a week until an appointment.

The twice weekly assessments were not initially initiated, not until the following month.

Failure to assess the resident as ordered had the potential for incomplete assessment findings.

Sources: Complaint log, interview with staff and review of the medication administration record and progress notes. [506]

Non-compliance with: FLTCA, 2021, s. 6 (7)

B. The licensee failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan related to their advanced care directives.

Rationale and Summary

A resident's plan of care noted their advanced care directive was at a specified level.

The resident was found in a condition where staff were required to provide care as per the advanced care directives.

Staff did not follow the directive according to the clinical records and interviews conducted by the home's management staff.

Sources: Review of the clinical record of a resident including their plan of care, progress notes, physician orders and Advanced Directive – Levels of Intervention Form, and interviews with staff. [168]

Non-compliance with: FLTCA, 2021, s. 6 (7)
C. The licensee failed to ensure that the care set out in the plan of care was provided to a resident as specified in their plan related to skin care.

Rationale and Summary
A resident's electronic Treatment Administration Record (eTAR) identified they were to have an intervention applied at all times.
An observation of the resident identified they were not using the intervention as required.
Failure to use the intervention as required may have put the resident at risk for skin breakdown.

Sources: Interview with staff, observation of the resident and review of the eTAR and progress notes. [506]

WRITTEN NOTIFICATION: WHEN ASSESSMENT, REVISION IS REQUIRED

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

Non-compliance with: LTCHA, 2007 s. 6 (10) b
On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA.
As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 6 (10) b of LTCHA.

A. The licensee failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed.

Rationale and Summary
A resident's clinical record indicated they had a device which was changed by an external care provider in January 2022.
Later that month a progress note directed staff to clarify the frequency of when the device was to be changed based on a statement made by the resident.
No further follow up was found related to the frequency of the device to be changed for seven weeks.
Staff then obtained an order for monthly device changes when it was noted that the resident did not have an order in place.
The resident was at risk when staff did not review and revise their plan of care in relation to the frequency of device to be changed.

Sources: Complaint log, a resident's clinical record and interviews with staff. [506]

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

B. The licensee failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed.

Rationale and Summary

A resident's SDM communicated a change in the resident's condition to a staff member and requested that a test be completed.

The plan of care identified that the resident had a history of a diagnosis and symptoms which were consistent with the changes reported by the SDM.

An order was received for the test to be completed at the request of the SDM; however, the sample for testing was not obtained for three days after the request was made and it was collected late in the day.

The sample was not picked up by the laboratory until day four after the request was made by the SDM.

It was confirmed that the sample should have been collected earlier on the third day as it would have been picked up by the laboratory that same day.

The resident's treatment was delayed when staff did not revise the plan of care and obtain the sample in a timely manner.

Sources: Complaint log, a resident's clinical record and interviews staff. [506]

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

C. The licensee failed to ensure that when a resident's care needs changed, the resident was reassessed, and the plan of care was reviewed and revised.

Rationale and Summary

A complaint alleged that a resident had a change in condition.

The resident's care plan identified they had specific orders related to the volume of fluids to be consumed a day.

Staff identified the resident had recently been reassessed following a change in condition and that their hydration/fluid status had changed. They acknowledged the resident's plan of care was not revised when their care needs changed and they no longer required the specific orders related to fluids.

The resident was at risk of not having their needs met when their plan of care was not reviewed and revised at the time their needs changed.

Sources: Complaint log, observations of the resident, review of the resident's electronic medical record and interviews with staff. [682]

WRITTEN NOTIFICATION REASSESSMENT, REVISION

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 6 (11) b

The licensee failed to ensure that the plan of care was reviewed, revised, and different approaches were considered, when a resident was reassessed related to falls.

Rationale and Summary

A resident had a fall.

The post fall assessment identified they were at a specified fall risk level.

Following the fall their plan of care had not been revised to include different approaches and the record identified that they were at a different fall risk level.

Later that month the resident sustained another fall.

The home's fall prevention policy directed registered staff to update the plan of care with associated risk level and interventions at the completion of a fall risk assessment.

Staff stated they would update the plan of care immediately with any changes to fall risk level or fall prevention strategies; however, different strategies were not implemented after either fall.

Since registered staff did not revise the resident's plan of care after they were reassessed, the resident was placed at risk for subsequent falls.

Sources: Falls policy, resident's electronic medical record and interviews with staff. [682]

WRITTEN NOTIFICATION: POLICIES, ETC, TO BE FOLLOWED, AND RECORDS

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 8 (1) (b)

On April 11, 2022, the Fixing Long-Term Care Act, 2021 (FLTCA) and O. Reg. 246/22 came into force, which repealed and replaced the Long-Term Care Homes Act, 2007 (LTCHA) and O. Reg. 79/10 under the LTCHA.

As set out below, the licensee's non-compliance with the applicable requirement occurred prior to April 11, 2022, where the requirement was under s. 8 (1) b of O. Reg 79/10.

A. The licensee failed to ensure that where LTCHA, 2007, or O. Reg. 79/10, required the licensee to put in place any policy related to falls prevention and management, the licensee was required to ensure that policy was complied with.

Rationale and Summary

In accordance with O. Reg. 79/10, s. 48 (1) 1 and in reference to O. Reg 79/10 , s.30 (1) 1, the licensee was required to ensure that in respect of the organized falls prevention and

management program there was a written description of the program that included relevant policies.
Specifically, staff did not comply with the licensee's policy for falls which required that when a fall occurred the resident was not moved before the completion of a preliminary assessment and staff were to complete an occurrence note each shift for 72 hours post fall.
i. A resident's clinical record identified they sustained a fall and a progress note identified PSW staff moved the resident prior to the completion of the RPN's assessment.
ii. A resident's clinical record identified they sustained a fall and an occurrence note was not completed by the registered nursing staff who worked on a night shift within the 72 hours of the fall as per the policy.
Failure to follow the falls policy as required had the potential for the resident to not be assessed for injuries in a timely fashion.

Sources: Review of a resident's clinical record; review of the home's policy Falls, and interviews with staff. [506]

Non-compliance with: O. Reg. 79/10, s. 8 (1) b

B. The licensee failed to ensure that where LTCHA, 2007, or O. Reg. 79/10, required the licensee to put in place any policy related to the Medication Management System, the licensee was required to ensure that policy was complied with.

Rationale and Summary
In accordance with O. Reg. 79/10, s. 114 (1) the licensee was required to develop an interdisciplinary medication management system and in accordance with O. Reg. 79/10, s. 114 (2) the licensee was required to ensure that policies and protocols were developed for the accurate storage of all drugs used in the home.

Specifically, staff did not comply with the home's policy for Min-Max Thermometer which identified that a thermometer was required for vaccine and medication refrigerators.

The policy identified staff were to check the thermometer twice a day and record the readings, date, time and signature on the Vaccine Temperature Log Chart provided by the Public Health Unit.

A review of the Vaccine Temperature Log Chart identified temperatures were not consistently recorded twice a day for 28 days over a period of four months.

As a result of incomplete Vaccine Temperature Log Charts an investigation was completed. Vaccines were removed from the home until the home was able to demonstrate compliance with the expectations of temperature monitoring and cold chain.

Sources: A review of policy Min-Max Thermometer, review of the Vaccine Temperature Log Chart and interviews with staff. [168]

Non-compliance with: O. Reg. 246/22, s. 11 (1) (b)

C. The licensee failed to ensure that where the Regulation required that the licensee instituted a housekeeping procedure that the procedure was complied with.

Rationale and Summary

In accordance with O. Reg 246/22, s. 93 (2) (a) (i) as part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee was required to ensure that procedures were developed and implemented for the cleaning of the home which included resident bedrooms, including floors.

Specifically, staff did not comply with procedure Daily Resident Room Cleaning which identified all resident rooms were to be cleaned at a minimum of daily, including to dry mop.

A resident identified their room was not cleaned daily.

Over the course of two days the floor of the resident's bedroom was monitored, and a piece of paper/garbage was noted on both days under the bed.

Staff confirmed they did not fully mop the resident's bedroom floor daily, during the observation period. They reported the resident's preference not to have the area under their bed cleaned under specific situations.

Sources: Review of procedure Daily Resident Room Cleaning, interview with a resident and observations of their room, and interview with staff. [168]

WRITTEN NOTIFICATION: GENERAL REQUIREMENTS

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 30 (2)

The licensee failed to ensure that any actions taken with respect to a resident, under the nursing and personal support services program, as required in LTCHA s. 8 (1) (a) were documented.

Rationale and Summary

Review of the clinical record for a resident identified that they sustained a fall.
A progress note written by registered nursing staff included that they were assessed by another health professional post fall.
The second health professional confirmed they had assessed the resident post fall but did not document their assessment in the clinical record, at the time of the assessment as the resident did not present with any injuries.

Sources: A resident's clinical record and interviews with staff. [506]

WRITTEN NOTIFICATION: BATHING

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 37

The licensee failed to ensure that a resident was bathed by the method of their choice.

Rationale and Summary
A complaint and interview with a resident identified their preferred method of bathing.
The home's bath list and the resident's care plan identified the resident's preference as verbalized by the resident.
A progress note indicated the resident's SDM voiced concerns related to the resident not provided bathing as requested.
Staff confirmed an occasion when they bathed the resident by a different method, not of their choice, and acknowledged they realized their error after the provision of care.
Failure to bathe the resident by the method of their choice put the resident at risk for dissatisfaction in the provision of care.

Sources: Complaint log, a resident's medical record and interview with staff. [682]

WRITTEN NOTIFICATION: MAINTENANCE SERVICES

NC#009 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg 246/22, s. 96 (1) (b)

The licensee failed to ensure that a schedule and procedure were in place for routine, preventative and remedial maintenance of the vaccine refrigerator and thermometers.

Rationale and Summary

The licensee had a Vaccine Storage and Handling Policy which included reference to cleaning the exterior of the vaccine refrigerator (including cooling coils); however, no details were included as to the specific maintenance tasks that were required by the manufacturer. A reference was made that any maintenance done to the refrigerator was to be recorded in a preventive maintenance log book. No other procedure was provided which identified the specific maintenance requirements of the vaccine refrigerator, who would complete the tasks and how often. In addition, no procedure was in place related to the maintenance of any thermometers used to record the vaccine refrigerator.

Staff revealed no person was allocated the task to ensure the vaccine refrigerator was maintained as per manufacturer's instructions.

Sources: Vaccine Storage and Handling Policy, Vaccine Storage Policy, Vaccine Refrigerator Temperature Monitoring, Min-Max Thermometer Policy, Thermometer Manual and interviews with staff. [736409]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC#010 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 102 (5) (a, b, c, d, e, f, g, h, i, j)

The licensee failed to ensure the designated IPAC lead had education and experience in infection prevention and control practices, including, infectious diseases; cleaning and disinfection; data collection and trend analysis; reporting protocols; outbreak management; asepsis; microbiology; adult education; epidemiology; or program management.

Rationale and Summary

A staff member was designated as the temporary IPAC lead.

The staff member identified they did not have any specific education or experience in IPAC practices outside of the general education that they received for their profession designation. They confirmed they did not have additional education and experience in the areas of IPAC practices, including, infectious diseases; cleaning and disinfection; data collection and trend analysis; reporting protocols; outbreak management; asepsis; microbiology; adult education; epidemiology; or program management.

Failure for the IPAC lead to have the required education or experience had the potential for concerns with the home's IPAC program.

Sources: A review of the Human Resources file and interview with staff. [168]

WRITTEN NOTIFICATION: DEALING WITH COMPLAINTS

NC#011 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s.108 (2)

A. The licensee failed to ensure that a documented record was kept in the home that included, the nature of the verbal complaint; the date the complaint was received; the type of action taken to resolve the complaint, which included the date of the action, time frames for actions to be taken, any follow-up action required; the final resolution; every date on which any response was provided to the complainant, a description of the response; and any response made in turn by the complainant.

Rationale and Summary

The licensee's Complaints policy identified when a verbal complaint could not be resolved within 24 hours, a written record of the investigation and outcome were documented. The complaint investigation form was used to document all actions of an investigation into a complaint.

A review of a resident's progress notes identified there were complaints made to the home regarding the care of the resident.

A review of the home's complaints log did not include the complaints that were verbalized to the home, nor was the investigation form completed.

Staff confirmed they did not document their investigation or responses to the complainant on the complaint investigation form nor include the verbal complaint to the complaints log.
Failure to maintain a record of complaints as required increased the potential for additional complaints and inconsistent actions to resolve concerns.

Sources: Complaints Policy, review of complaints binder and progress notes related to a resident and interview with staff. [506]

Non-**compliance with: O. Reg. 246/22, s. 108 (2)**

B. The licensee failed to ensure that a documented record was kept in the home that included, the nature of the verbal complaint; the date the complaint was received; the type of action taken to resolve the complaint, which included the date of the action, time frames for actions to be taken, any follow-up action required; the final resolution; every date on which any response was provided to the complainant, a description of the response; and any response made in turn by the complainant.

Rationale and Summary
The licensee's complaint policy identified when a verbal complaint could not be resolved within 24 hours, a written record of the investigation and outcome were documented. The complaint investigation form was used to document all actions of an investigation into a complaint.
The complaint log included an entry which identified an ongoing investigation into a resident's SDM report of operational and care concerns.
No complaint investigation form was available regarding the nature of the complaint/concerns, any actions taken to resolve the complaint/concerns, or any responses provided to the complainant.
Staff confirmed they did not document their investigation or responses to the complainant on the complaint investigation form related to the concerns reported.
Failure to maintain a record of complaints as required increased the potential for additional complaints and inconsistent actions to resolve concerns.

Sources: Complaint log, Complaints Policy, and interview with staff. [682]

WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

NC#012 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, *s. 131 (2)*

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

Rationale and Summary
A resident's clinical record included they had physician's orders faxed to the home which were clarified by the physician on the same day.

The orders were to be implemented prior to the resident's follow up appointment and included a change in dosage to a specific drug.
The following month another fax was received from the physician which directed the home to initiate the previous orders which had not yet been processed.
Staff confirmed the physician's orders were not processed, and the drug dosage was not initially changed as prescribed.
Failure to receive the drug as prescribed by the physician put the resident at risk for not being at a therapeutic drug level.

Sources: A resident's clinical record, physician's orders, and interviews with staff. [506]

Non-compliance with O. Reg. 79/10, s. 131 (2)

B. The licensee failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

The home had a Medical Directive for the administration a specific drug.

This directive provided orders for staff to administer the drug and included direction that the person to receive the drug was not to have previously received the complete series of the drug as required.

A record identified a resident had already received four doses of the drug. Additionally, their consent form, identified they received a fifth dose of the drug, a dose not recorded in the initial record.

Documentation identified the drug was administered five times and not four times as recommended.

Failure to administer the drug in accordance with the directions for use by the prescriber had the potential for the resident to experience side effects on an additional occasion.

Sources: Review Medical Directive &/or Delegate Template, review of clinical health record of a resident and interviews with staff. [168]

WRITTEN NOTIFICATION: RESIDENT RECORDS

NC#013 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 231 (b)

The licensee failed to ensure that a resident's written record was kept up to date at all times related to a consent forms and administration records.

Rationale and Summary

A report identified potential concerns with records of consent and documentation for the administration of a drug administered over the course of a month.

The health records of a resident included documentation that a type of drug was administered; however, the record did not include a written consent for the administration.

The consent form would have contained specific information including, but not limited to: if consent was obtained, when and by who, as well as when and which drug was administered, the lot number, dosage amount and number, the site, who administered and the date and time the drug was administered.

Staff who administered the drugs confirmed written consent forms were completed prior to administration and administration details were recorded on this record.

As a result of poor record keeping related to the drug, recommendations were made that all residents who received the drug during the identified time period, have the drug readministered and the records altered.

Sources: A CIS report, review of clinical health records for a resident and interviews with staff. [168]

WRITTEN NOTIFICATION: CMOH AND MOH

NC#014 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 272

The licensee failed to ensure that Directive #3 issued by the Chief Medical Officer of Health (CMOH) was followed in relation to enhanced environmental cleaning and disinfection of frequently touched surfaces in an outbreak affected area of the long-term care home (LTCH).

Rationale and Summary

Directive #3 set out the guidance related to enhanced environmental cleaning and disinfection of frequently touched surfaces with further reference to “Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition”. The best practice document includes the frequency for cleaning and disinfecting such surfaces more than once per day during an outbreak. In addition, the licensee’s policy included the same direction for staff.

According to the staff, staffing shortages in the home made it difficult to clean and disinfect frequently touched surfaces in outbreak areas of the home more than once per day. Staff confirmed they cleaned the outbreak area only once per day.

Sources: Environmental Services Policy and Procedures and interviews with staff. [736409]

COMPLIANCE ORDER CO#001 POLICIES, ETC, TO BE FOLLOWED, AND RECORDS

NC#015 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: O. Reg. 79/10, s. 8 (1) b

The Inspector is ordering the licensee to:

LTCHA, 2007, s. 153 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The licensee failed to comply with O. Reg. 79/10, s. 8 (1) b

The licensee shall:

1. Review documentation expectations for resident drug records including but not limited all required records with any registered nursing staff who is responsible to administer and or document the administration of the drug, to ensure that staff are aware of the expectations and requirements.
2. All staff administering and or documenting a specific drug administration will be audited for their record keeping within 48 hours following the administration of the specific drug to residents until the licensee is satisfied that all relevant records recorded by the staff member are complete, clear, and accurate.
   The auditing may be completed by any staff member (including management) who has completed a review of documentation expectations and has access to all required software.
3. A record of the documentation expectation reviews conducted by staff and auditing completed shall be maintained in the home and be available on the request of an inspector.

Grounds

Non-compliance with: O. Reg. 79/10 s 8 (1) (b)

The licensee failed to ensure that where the LTCHA, 2007 or O. Reg 79/10, required the licensee of a long-term care home put into place any policy that the policy was complied with.

Rationale and Summary

As required in LTCHA, 2007 s. 8 the licensee was required to ensure there was an organized program of nursing services to meet the assessed needs of residents.

Specifically, the home did not comply with their policy Documentation Guidelines which identified documentation was to be accurate, clear and a comprehensive picture of the nurse's interventions and staff were to sign with their first initial and last name and professional designation.

i. A resident consented to and was administered a drug.

A review of a provincial record identified that they were administered the drug on a specified date including the name of the drug, lot number, dose number, by who, when and the location.
A review of their consent form identified they received a drug; however, there was no record of the name of the drug administered, the lot number, the dose, the name/signature, or designation of who administered the drug on the record.
A review of a third record, a report in PCC, identified the resident received a drug on a specified date; however, no time was recorded, nor did the record include the name/signature/designation of the staff member who administered the drug or location given.

ii. A resident's consent form included they were administered a drug on a specified date; however, the record did not include the name of the drug administered, the lot number, the dose, the last name of the person who administered the drug nor their designation.
The administration of a dose was not recorded consistently in other records as required.

As a result of poor record keeping related to the drug, recommendations were made that all residents who received the drug during the identified time period, have the drug readministered and the records altered.

Sources: Review of Documentation Guidelines, a review of the clinical health records for two residents and interviews with staff. [168]

This order must be complied with by July 26, 2022

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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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/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
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- 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:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- 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:

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7
Telephone: 1-800-461-7137
HamiltonSAO.moh@ontario.ca

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
email: 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.