Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 9, 2020	2020_738753_0017	023888-19, 023889-19, 023890-19, 023891-19, 012245-20, 013997-20	Follow up

Licensee/Titulaire de permis

peopleCare Communities Inc.
735 Bridge Street West WATERLOO ON N2V 2H1

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

peopleCare Hilltop Manor Cambridge
42 Elliott Street CAMBRIDGE ON N1R 2J2

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

KATHERINE ADAMSKI (753), NUZHAT UDDIN (532)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 27-30, August 4-7, 10-11, 2020

The following intakes were completed during this inspection:
Log #: 023888-19 follow-up related to reporting medication incidents
Log #: 023889-19 follow-up related to plan of care
Log #: 023890-19, and Log #: 023891-19 follow-up related to staffing, training, and medication administration
Log #: 013997-20 and Log #: 012245-20 critical incidents related to fall prevention management

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Executive Director of Nursing (EDON), Directors of Resident Care (DRC), Fall Program Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), residents and Personal Support Workers (PSW).

Observations were completed of resident's and staff to resident care provisions. Review of relevant documentation was completed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 VPC(s)**
- **4 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 131. (2)	CO #002	2019_821640_0030	532

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	Légende 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. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all medication incidents were documented and reported.

This inspection was completed as a follow-up to compliance order #001 from inspection #2019_821640_0029 issued on December 10, 2019, with a compliance date of February 28, 2020, related to documentation and reporting of medication incidents.

The licensee's pharmacy service provider policy "Medication Incident Reporting and Management", policy #IIA02 last revised December 17, 2019, directed registered staff to report any medication incidents to a Pharmacist. It noted that a medication error was any preventable event that may cause a patient harm. Such events may be related to professional practice, procedures, systems and administration. The policy stated that the registered staff were to report to the resident, the resident's substitute decision-maker, the prescriber of the drug, the resident's attending prescriber or the registered nurse in the extended class attending the resident.

The Executive Director of Nursing (EDON) #100 stated that they had no medication incidents for the month of July and therefore there were no medication incident reports on file.

The Medication Administration Audit Reports for the period of July 1- 27, 2020, were reviewed in relation to missed medications for the entire home and it was noted that there were three medications that were either missed or not administered to the residents as prescribed.

The Medication Administration Audit Reports were reviewed for the period of July 1-27, 2020, in relation to late administration of medication (two hours) for the entire home and it was noted that there were 95 medications that were administered over two hours late including time-sensitive medications.

RN #110 reviewed the Medication Administration Audit Reports with Inspector #532 and acknowledged that they administered the medications late. They said that the time-sensitive medications should be administered safely within 30 minutes of the prescribed time.

Resident Director of Care (RDOC) #108 reviewed the Medication Administration Audit Reports dated July 1-27, 2020, for the entire home and validated the findings for each resident that had the late medication administered or missed medication.

EDON #100 stated that they had not run the Medication Administration Audit Reports in the past, however, they were now aware of the report and had reviewed it with RDOC #108. They stated that the medications should be administered based on the administration times published on the electronic medication administration records (MARs). The EDON acknowledged that the late administration of medications included time-sensitive medications and narcotics. The EDON stated that the medications that were either administered late or not given by the registered staff should be considered as medication incidents.

The licensee failed to ensure that all medication incidents were documented and reported. [s. 135. (1)]

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 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.

This inspection was completed as a follow-up to compliance order #003 from inspection #2019_821640_0030 issued on December 10, 2019, with a compliance date of March 6, 2020, related to the administration of medications.

A. The licensee's pharmacy service provider policy called "Administration procedures-all medications", policy #IIA01A last revised December 17, 2019, stated that one of the guiding principles was timeliness. Registered staff were directed to administer medications based on the administration times published on the electronic Medication Administration Records (eMARs), in accordance with best practice for the timely administration of medications. The policy also included the time-sensitive medications (but are not limited to): anti-parkinson's agents (Sinemet) and seizure medications such as Dilantin. The policy stated as part of the procedure, staff were to review the eight "rights" of medication administration prior to administering the medication, one of which was the correct time.

The Medication Administration Audit Reports for the period of July 1- 27, 2020, were reviewed in relation to missed medications for the entire home and it was noted that there were three residents whose medications had been either missed or not administered as prescribed and there was no documentation in Point Clink Care (PCC) to support why the medication was missed.

Resident's #023, #024, and #025 had not received a prescribed medication on specified dates and at specified times in July 2020.

The Medication Administration Audit Reports were reviewed for the period of July 1-27, 2020, in relation to late administration of medication (two hours) for the entire home and it was noted that there were 95 medications that were administered over two hours late

including time-sensitive medications.

Six residents whose medications were ordered for a specified time in the day, received these medications between two and four hours late during the review period. One of the resident's affected said that there were times when the staff administered the medication late and did not take their medication seriously. The resident said that their symptoms would get worse if the medication was not administered on time.

Registered Nurse (RN) #110 reviewed the Medication Administration Audit Reports with Inspector #532 and acknowledged that the medications had been administered late. They stated that the time sensitive medications should be administered safely within 30 minutes of the prescribed time.

Review of the licensee report from inspection #2019_821640_0029 issued on December 10, 2019, showed that the Medication Administration Audit Report was reviewed with RN #110 during that inspection and the RN was fully aware of the timely administration of medications.

EDON #100 stated that the medication was not administered to residents as specified by the prescriber when they were being administered late or missed.

B. Step 4 from order #002 was not completed as ordered.

Registered staff meeting minutes were reviewed dated November 18, 2020, and the policy related to medication reconciliation on admission, readmission, transfer and discharge was said to be attached to the minutes. It was noted that 10 registered staff attended the meeting, however, there were 26 registered staff at the home. EDON #100 stated that all registered staff received a copy of the minutes, however, there were no sign in records to indicate that the registered staff read the minutes. The minutes did not indicate that the medication reconciliation policy was reviewed at the meeting as there was no reference to the policy in the minutes.

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that care set out in the plan of care for resident #012 was provided to the resident as specified in their plan.

This inspection was completed as a follow-up to compliance order #001 from inspection #2019_821640_0030 issued on December 10, 2019, with a compliance date of February 7, 2020, related to plan of care.

Resident #012 was admitted to the home requiring specialized equipment.

The resident's plan of care documented that staff were to ensure interventions were in place for the resident's safety.

On August 4, 2020, the resident’s care plan was updated to include further interventions related to safety and their specialized equipment.

Observations of the resident conducted by inspector #753 over the course of the inspection showed that the interventions related to safety were not in place.

The licensee failed to ensure that care set out in the plan of care for resident #012 was provided to the resident as specified in their plan. [s. 6. (7)]

2. The licensee failed to ensure that the plan of care for resident #003 was reviewed and revised when the resident's care needs changed.

A Critical Incident System (CIS) report was submitted to the Director when resident #003 sustained a fall resulting in significant injuries and their passing.

Resident #003 was at high risk of falls and had a falls history.

Personal Support Worker (PSW) #105 stated that resident #003 did not have fall prevention interventions in place. RN #106 stated that a piece of equipment required by the resident contributed to the resident's falls risk. Multiple records documented that the resident had reported that their specialized equipment had caused them to fall.

Records showed that the resident was last reassessed several months prior to being prescribed the specialized equipment and there were no assessments related to this new equipment. Review of the resident’s tasks and Final Care Plan Prior to Close showed there was no plan of care related to the equipment or the resident's high risk of falls at the time of this incident.

RDOC #118 stated that resident #003 was a high falls risk and the resident had not been assessed related to their change in condition or falls risk related to the new equipment.

The licensee failed to ensure that the plan of care for resident #003 was reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

3. The licensee failed to ensure that when resident #002 was reassessed and the plan of care for falls prevention was revised because care set out in the plan had not been effective, that different approaches were considered in the revision of the plan of care s. 6. (11) (b).

A CIS report was submitted to the Director related to an unwitnessed fall sustained by resident #002, that resulted in a significant injury.

Following the resident #002's first fall in the home, the resident’s risk of falls had been upgraded to high. A review of the resident's Fall Risk Screening and Post Fall Assessments showed that they had sustained eight falls over several months resulting in multiple injuries.

Resident #002's plan of care related to falls prevention management documented that falls prevention interventions were initiated on a specific date, modified shortly after, and not modified again until after the resident had sustained a fall resulting in a significant injury.

The Fall Risk Screening and Post Fall Assessments completed over several months documented no change to interventions except to reinforce use of call bell.

RPN #116 reviewed the resident’s care plan and agreed that the resident’s fall prevention interventions had not been modified for several months.

Fall Lead #117 reviewed Monthly Falls Meeting Notes and stated that resident #002 was not discussed frequently at these meetings, could not provide documentation that different interventions had been trialed on the resident, and stated that had different interventions been trialed, these would have been documented in the resident’s care plan.

The licensee failed to ensure that when resident #002 was reassessed and the plan of care was revised because care set out in the plan had not been effective, that different approaches were considered in the revision of the plan of care s. 6. (11) (b). [s. 6. (11) (b)]

Additional Required Actions:

CO # - 003, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 when resident #002 or any other resident is reassessed and the plan of care is revised because care set out in the plan has not been effective, that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Resident #017 reported an allegation of staff to resident abuse and neglect to inspector #753 related to an incident that occurred in early August 2020.

Review of critical incidents in the Long Term Care Portal showed that a critical incident related to this allegation was not submitted to the Director as per the Long Term Care Home Act.

A progress note written by RPN #119 documented that they had notified their charge nurse immediately of the allegation and that both the charge nurse and RPN #119 notified the on call manager.

DROC #118 acknowledged that this allegation had been reported to them by the On Call Manager #121.

ED #114 acknowledged that an allegation of abuse and neglect made by resident #017 had been reported to them, but it was not reported to the Director.

The licensee failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm. [s. 24. (1)]

Issued on this 15th day of September, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	KATHERINE ADAMSKI (753), NUZHAT UDDIN (532)
Inspection No. / No de l’inspection :	2020_738753_0017
Log No. / No de registre :	023888-19, 023889-19, 023890-19, 023891-19, 012245-20, 013997-20
Type of Inspection / Genre d’inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 9, 2020
Licensee / Titulaire de permis :	peopleCare Communities Inc. 735 Bridge Street West, WATERLOO, ON, N2V-2H1
LTC Home / Foyer de SLD :	peopleCare Hilltop Manor Cambridge 42 Elliott Street, CAMBRIDGE, ON, N1R-2J2
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Mike Dickin

To peopleCare Communities Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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 # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_821640_0029, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction 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 prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Order / Ordre :

The licensee must comply with O. Reg. 79/10, s. 135 (1).

Specifically, the licensee must:

1) Ensure that all medication incidents are recorded using the licensee's documentation process,

2) Ensure that all medication incidents are reported to all parties named in s.135(1),

3.a) Develop and implement a medication administration audit tool to ensure the timely administration of medications, and

b) Ensure that a record is kept of the audit that includes who is responsible for conducting the audit and the action taken in response to the results.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #001 from inspection #2019_821640_0029 issued on December 10, 2019, with a compliance date of February 28, 2020.

The licensee was ordered to comply with O. Reg. 79/10, s. 135 (1). Specifically, the licensee must:
1) Ensure that all medication incidents are reported using the licensee's documentation process and,
2) Ensure that all medication incidents are reported to all parties named in s. 135 (1).

The licensee failed to complete step 1) and 2) ensuring that all medication incidents were documented and reported.

The licensee's pharmacy service provider policy "Medication Incident Reporting and Management", policy #IIA02 last revised December 17, 2019, directed registered staff to report any medication incidents to a Pharmacist. It noted that a medication error was any preventable event that may cause a patient harm. Such events may be related to professional practice, procedures, systems and administration. The policy stated that the registered staff were to report to the resident, the resident's substitute decision-maker, the prescriber of the drug, the resident's attending prescriber or the registered nurse in the extended class attending the resident.

The Executive Director of Nursing (EDON) #100 stated that they had no medication incidents for the month of July and therefore there were no medication incident reports on file.

The Medication Administration Audit Reports for the period of July 1- 27, 2020, were reviewed in relation to missed medications for the entire home and it was noted that there were three medications that were either missed or not administered to the residents as prescribed.

The Medication Administration Audit Reports were reviewed for the period of July 1-27, 2020, in relation to late administration of medication (two hours) for the entire home and it was noted that there were 95 medications that were administered over two hours late including time-sensitive medications such as anti-parkinson's agents (Sinemet).

RN #110 reviewed the Medication Administration Audit Reports with Inspector #532 and acknowledged that they administered the medications late. They said

that the time-sensitive medications should be administered safely within 30 minutes of the prescribed time.

Resident Director of Care (RDOC) #108 reviewed the Medication Administration Audit Reports dated July 1-27, 2020, for the entire home and validated the findings for each resident that had the late medication administered or missed medication.

EDON #100 stated that they had not run the Medication Administration Audit Reports in the past, however, they were now aware of the report and had reviewed it with RDOC #108. They stated that the medications should be administered based on the administration times published on the electronic medication administration records (MARs). The EDON acknowledged that the late administration of medications included time-sensitive medications and narcotics. The EDON stated that the medications that were either administered late or not given by the registered staff should be considered as medication incidents.

The licensee failed to ensure that all medication incidents were documented and reported. [s. 135.(1)] (532)

The severity of this issue was determined to be level 2 as there was minimal harm or minimal risk of harm. The scope of this issue was determined to be 3, as it was widespread. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA and three or fewer compliance orders that included:
•Written Notification (WN) issued June 12, 2018, (2018_735659_0010),
•WN issued June 20, 2019, (2019_787640_0018), and
•Compliance Order (CO) issued December 10, 2019, with a compliance due date of February 28, 2020, (2019_821640_0029).
(532)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 05, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre : 002

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

Linked to Existing Order / Lien vers ordre existant: 2019_821640_0030, CO #003;

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 must comply with s. 131 (2) of O. Reg. 79/10.
Specifically, the licensee must ensure:
1) That medications are administered for residents #014, #018, #019, #020, #021, #022, and any other resident in accordance with the home's policy for medication administration.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #002 from inspection #2019_821640_0030 issued on December 10, 2019, with a compliance date of March 6, 2020.

The licensee was ordered to comply with O. Reg. 79/10, s. 131 (2).
Specifically, the licensee must:
1) Develop a staffing plan for the nursing department,
2) Develop a process to ensure that when short registered staff, that all residents receive their medications at the time prescribed,
3) Develop a plan to ensure that when short registered staff, staff have a process to identify high-risk medications to ensure their timely administration, and
4) Provide training to all registered staff regarding the process of identifying high-risk medications and the process of timely administration of all medications when short registered staff.

The licensee completed steps 1), 2), and 3).
The licensee failed to complete step 4) providing training to staff regarding high-

risk medications and the timely administration of medications.

A. The licensee's pharmacy service provider policy called "Administration procedures-all medications", policy #IIA01A last revised December 17, 2019, stated that one of the guiding principles was timeliness. Registered staff were directed to administer medications based on the administration times published on the electronic Medication Administration Records (eMARs), in accordance with best practice for the timely administration of medications. The policy also included the time-sensitive medications (but are not limited to): anti-parkinson's agents (Sinemet) and seizure medications such as Dilantin. The policy stated as part of the procedure, staff were to review the eight "rights" of medication administration prior to administering the medication, one of which was the correct time.

The Medication Administration Audit Reports for the period of July 1- 27, 2020, were reviewed in relation to missed medications for the entire home and it was noted that there were three residents whose medications had been either missed or not administered as prescribed and there was no documentation in Point Clink Care (PCC) to support why the medication was missed.

Resident's #023, #024, and #025 had not received a prescribed medication on specified dates and at specified times in July 2020.

The Medication Administration Audit Reports were reviewed for the period of July 1-27, 2020, in relation to late administration of medication (two hours) for the entire home and it was noted that there were 95 medications that were administered over two hours late including time-sensitive medications.

Six residents whose medications were ordered for a specified time in the day, received these medications between two and four hours late during the review period. One of the resident's affected said that there were times when the staff administered the medication late and did not take their medication seriously. The resident said that their symptoms would get worse if the medication was not administered on time.

Registered Nurse (RN) #110 reviewed the Medication Administration Audit Reports with Inspector #532 and acknowledged that the medications had been

administered late. They stated that the time sensitive medications should be administered safely within 30 minutes of the prescribed time.

Review of the licensee report from inspection #2019_821640_0029 issued on December 10, 2019, showed that the Medication Administration Audit Report was reviewed with RN #110 during that inspection and the RN was fully aware of the timely administration of medications.

EDON #100 stated that the medication was not administered to residents as specified by the prescriber when they were being administered late or missed.

B. Step 4 from order #002 was not completed as ordered.

Registered staff meeting minutes were reviewed dated November 18, 2020, and the policy related to medication reconciliation on admission, readmission, transfer and discharge was said to be attached to the minutes. It was noted that 10 registered staff attended the meeting, however, there were 26 registered staff at the home. EDON #100 stated that all registered staff received a copy of the minutes, however, there were no sign in records to indicate that the registered staff read the minutes. The minutes did not indicate that the medication reconciliation policy was reviewed at the meeting as there was no reference to the policy in the minutes.

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

The severity of this issue was determined to be a level 2 as there was minimal harm or minimal risk of harm. The scope of the issue was a level 3 as it was widespread. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA and three or fewer compliance orders that included:
•VPC issued June 12, 2018, (2018_735659_0010),
•CO issued June 20, 2019, with a compliance due date of September 20, 2019, (2019_787640_0018), and
•CO issued December 10, 2019, with a compliance due date of March 6, 2020, (2019_821640_0030). (532)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Oct 05, 2020

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

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 # / No d'ordre : 003

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

Linked to Existing Order / Lien vers ordre existant: 2019_821640_0030, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must comply with s. 6 (7) of the LTCHA, 2007.

Specifically, the licensee must ensure that resident #012's environment is maintained clutter-free to mitigate their risk of falling, as set out in the resident's plan of care.

Grounds / Motifs :

1. The licensee failed to comply with compliance order #001 from inspection 2019_821640_0030 issued on December 19, 2019, with a compliance date of February 07, 2020.

The licensee was ordered to comply with s. 6 (7) of the LTCHA.
Specifically the licensee was ordered to ensure that resident #001 and any other resident, received the level of assistance needed for safety as set out in the resident's plan of care.

The licensee failed to ensure that care set out in the plan of care for resident #012 was provided to the resident as specified in their plan.

This inspection was completed as a follow-up to compliance order #001 from inspection #2019_821640_0030 issued on December 10, 2019, with a compliance date of February 7, 2020, related to plan of care.

Resident #012 was admitted to the home requiring specialized equipment.

The resident's plan of care documented that staff were to ensure interventions were in place for the resident's safety.

On August 4, 2020, the resident's care plan was updated to include further interventions related to safety and their specialized equipment.

Observations of the resident conducted by inspector #753 over the course of the inspection showed that the interventions related to safety were not in place.

The licensee failed to ensure that care set out in the plan of care for resident #012 was provided to the resident as specified in their plan. [s. 6. (7)]

The severity of this issue was determined to be level 2 as there was minimal harm or minimal risk of harm. The scope of this issue was determined to be level 1 as it related to one of three residents reviewed. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA and three or fewer compliance orders that included:
•VPC issued June 20, 2019 under Inspection #2019_787640_0018; and
• CO issued December 10, 2019, with a compliance due date of February 7, 2020, (2019_821640_0030). (753)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 05, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 # / No d'ordre : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee must comply with s. 6. (10) of the LTCHA, 2007.
Specifically, the licensee must ensure that when any resident's care needs change in relation to falls prevention, that the plan of care is reviewed and revised to reflect changes.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care for resident #003 was reviewed and revised when the resident's care needs changed.

The licensee failed to ensure that the plan of care for resident #003 was reviewed and revised when the resident's care needs changed.

A Critical Incident System (CIS) report was submitted to the Director when resident #003 sustained a fall resulting in significant injuries and their passing.

Resident #003 was at high risk of falls and had a falls history.

Personal Support Worker (PSW) #105 stated that resident #003 did not have fall prevention interventions in place. RN #106 stated that a piece of equipment required by the resident contributed to the resident's falls risk. Multiple records documented that the resident had reported that their specialized equipment had caused them to fall.

Records showed that the resident was last reassessed several months prior to being prescribed the specialized equipment and there were no assessments related to this new equipment. Review of the resident's tasks and Final Care Plan Prior to Close showed there was no plan of care related to the equipment or the resident's high risk of falls at the time of this incident.

RDOC #118 stated that resident #003 was a high falls risk and the resident had not been assessed related to their change in condition or falls risk related to the new equipment.

The licensee failed to ensure that the plan of care for resident #003 was reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 3 history as they had previous non-compliance with this sub-section of the LTCHA that included:
• Voluntary Plan of Correction (VPC) issued June 20, 2019, (2019_787640_0018).
(753)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 05, 2020

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

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

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 Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 9th day of September, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Katherine Adamski

Service Area Office /
Bureau régional de services : Central West Service Area Office