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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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 24, 2021	2021_901759_0005	006270-21, 007154-21, 007990-21, 008078-21, 011095-21	Critical Incident System

Licensee/Titulaire de permis

Orillia Long Term Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street Midland ON L4R 2E1

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

Leacock Care Centre
25 Museum Drive Orillia ON L3V 7T9

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

KEARA CRONIN (759), TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 12-16, and 19-22, 2021

The following intakes were inspected upon during this Critical Incident System Inspection:

- One intake related to an incident of resident to resident physical abuse resulting in injury;
- One intake related to an alleged medication incident;
- Two intakes related to falls resulting in an injury to two residents; and
- One intake related to an incident that resulted in a resident being transported to hospital.

A Follow-Up Inspection #2021_901759_0004 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (DOC), Co-DOCs, Staff Educators, Nurse Managers, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), RPN Student, Environmental Services Manager, Restorative Care Coordinator, Physician, Physician's Assistant, Housekeepers, and residents.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed infection prevention and control (IPAC) practices, reviewed cooling and air temperature requirements, reviewed relevant health care records, reviewed the home's internal investigation notes, and reviewed licensee policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

11 WN(s)
7 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or medication cart that was secured and locked.

a) A resident's Substitute Decision Maker (SDM) came to visit and found a medication left on the resident's bedside table. After review and investigation it was found that the medication was left at the beside after it was given to the resident.

An RN indicated that they put the medication down to take the resident's vital signs, left the room, and left the medication on the resident's table

b) An unattended medication cart was unlocked near the nursing station that also had two medications on top of the cart. There was a resident in the vicinity exiting the bathroom near the medication cart.

When an RPN Student returned they indicated that they forgot to lock the medication cart.

As a result, improper storage of the medications allowed for easy access by residents and there was actual risk of harm if the medications were accessed by residents.

Sources: Inspector #759's observations; a CI report; the homes investigation notes; the home's policies; interviews with an RN, RPN Student, and other relevant staff. [s. 129. (1) (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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).

Findings/Faits saillants :

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

A resident fell and sustained an injury.

The resident's transfer and mobility status had changed post-fall. Their care plan was not updated to identify the changes in their care needs after the fall and did not communicate the residents appropriate care needs to staff members providing care to the resident.

A Nurse Manager indicated that the resident's care plan was not updated to reflect the changes in their care needs.

Sources: A CI report, a resident's electronic progress notes, the resident's health care record, interviews with a Nurse Manager and other relevant staff. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that their written policy that promoted zero tolerance of abuse and neglect was complied with related to not immediately initiating an investigation following an alleged incident of physical abuse between two residents.

An incident occurred between two residents that resulted in an injury to one of the residents and there was no internal investigation conducted.

The Resident Rights, Care and Services- Abuse-Zero Tolerance Policy for Resident Abuse and Neglect policy indicated that staff would commence a preliminary investigation by obtaining written and signed statements from all witnesses, document all pertinent information in the resident’s record and complete the resident incident reports.

Inspector #543 interviewed the Administrator and the DOC regarding investigating the incident that occurred. They verified that there was no formal investigation conducted.

Sources: A CI Report; the policy titled "Resident Rights, Care and Services- Abuse-Zero Tolerance Policy for Resident Abuse and Neglect"; resident's electronic progress notes; the resident’s health care record; interviews with the Administrator, DOC, and other relevant staff. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls when a resident fell.

A resident fell and sustained an injury. There was no post fall assessment completed for the fall that had occurred.

The Restorative Care Coordinator indicated that a post fall assessment must be completed by a registered staff member for every fall. They indicated that a post fall assessment was not completed for the resident's fall.

Sources: A CI report; a resident’s electronic progress notes; the resident’s health care record; interviews with relevant staff. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident had written approaches to care that included techniques and interventions to prevent, minimize or respond to their responsive behaviours.

An incident occurred between two residents that resulted in an injury to one of the residents.

A resident’s current care plan did not include triggers, or strategies developed and implemented to respond to responsive behaviours as per the Resident Rights, Care and Services-Responsive Behaviours Program.

A Co-DOC indicated that the the resident's care plan should indicate specific triggers, strategies including techniques and interventions, to prevent or minimize the resident's responsive behaviours. Inspector #543 and the Co-DOC went over the care plan together, and the Co-DOC verified that the resident's care plan lacked information to prevent responsive behaviours and indicated that the care plan was very generic.

Therefore, the resident's care plan did not include strategies to minimize their responsive behaviours towards co-residents, which placed co-residents at an increased risk of harm.

Sources: a CI report; a resident’s electronic progress notes; the resident’s health care record; staff and Co-DOC interviews. [s. 53. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours are developed to meet the needs of residents with responsive behaviours, to be implemented voluntarily.

WN #6: 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 has failed to ensure that a potential medication incident involving a resident was documented with a record of the immediate actions taken to assess and maintain the resident's health.

A potential medication incident was discovered and there was no documentation of the immediate actions taken to assess and maintain the resident's health at the time that it was discovered.

An RN confirmed that they did not document the actions that they took. As a result, there was no record of the residents status at the time the incident was discovered.

Sources: A CIS report; A "Medication Incident Form"; a resident's progress notes; the homes investigation notes; and interviews with an RN and other staff members. [s. 135. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 174.1 Directives by Minister

Specifically failed to comply with the following:

s. 174.1 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. 2017, c. 25, Sched. 5, s. 49.

Findings/Faits saillants :

1. The licensee failed to comply with a Minister’s Directive when they did not document immediate actions taken to assess a resident following an incident, did not report the incident to the resident's substitute decision-maker and physician, and did not report the incident the following business day to the Director.

a) A resident experienced an incident and documentation failed to support that the incident was reported to the physician, the SDM, and did not include actions that were taken to assess and maintain the residents health.

Despite actions taken by an RPN and an RPN Student, to address the incident, the RPN indicated that they did not document their actions taken or notify the physician.

A Physician Assistant indicated they were not made aware of the incident until at a later time.

A Co-DOC was in agreement that more should have been documented during these occurrences.

b) A resident experienced an incident that required transfer to hospital.

Upon review of the resident's progress notes, minimal documentation was noted relating to immediate actions taken to assess and maintain the resident's health status.

The DOC indicated there was a lot of education that needed to be provided and there could have been more precise documentation and follow up regarding the incidents.

c) A CI report was submitted to the Director relating to a resident's transfer to hospital.

The Administrator indicated that they were late reporting the incident and believed it was due to the lack of knowledge and education.

Sources: A Minister’s Directive; a CI report; a resident's records; the home's investigation notes; a home's policy; and interviews with an RPN, RPN Student, the DOC, the Administrator, and other relevant staff members. [s. 174.1 (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Minister may issue operational or policy directives respecting long-term care homes where the Minister considers it to be in the public interest to do so, the long-term care home shall carry out every operational or policy directive that applies to the long-term care home, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

The homes policy titled "Operation of homes - Infection Control - Outbreak Management - Additional Precautions" last reviewed June 1, 2020, indicated that all staff will comply with additional precautions as communicated and that Registered Staff will post signage and ensure supplies are readily available to support additional precautions.

An RN indicated that a resident was on isolation precautions as they experienced a symptom earlier in the day. There was no signage outside of the resident's room. However, an isolation cart with gowns, gloves, masks, and eye protection was available outside the room.

As a result, no signage to reflect the required isolation precautions resulted in a risk of staff or visitors not donning appropriate personal protective equipment (PPE) that was required to prevent disease transmission.

Sources: the policy titled "Operation of homes - Infection Control - Outbreak Management - Additional Precautions" last reviewed June 1, 2020; Inspector #759's observations; and interviews with an RN and other staff members. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the program, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in writing in every designated cooling area in the home.

The Environmental Services Manager indicated that the home had designated cooling areas served by air conditioning in the dining rooms, activity rooms and TV rooms, and that nursing staff monitors air temperatures three times a day.

Air temperatures were recorded in the dining rooms but not in the remainder of the designated cooling areas in the home. The Administrator indicated that temperatures were being taken in dining rooms, but not in every designated cooling area.

Sources: April 1, 2021 memo regarding amendments to Ontario Regulation 79/10 under the Long-Term Care Homes Act, 2007 related to enhanced cooling requirements; Air Quality Recording Forms and Cooling Area Recording Forms; and interviews with the Administrator and Environmental Services Manager. [s. 21. (2) 3.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, that caused an injury to a resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

A critical incident was reported to the Director as a resident was transferred to the hospital and had a significant change in condition.

A Co-DOC indicated that the incident was reported late.

Sources: a CI report; a resident's electronic progress notes; the resident's health care record; and staff and interviews. [s. 107. (3) 4.]

WN #11: 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 has failed to ensure that drugs administered to a resident were in accordance with the directions for use specified by the prescriber.

This finding is further evidence to support Compliance Order (CO) #001 that was issued during inspection #2021_841679_0010 pursuant to O. Reg. 79/10, s. 131. (2). with a compliance due date of May 31, 2021.

A resident had an order for a medication to be administered.

The resident's Electronic Medication Administration Record (EMAR) was reviewed and it was identified that an RPN administered a "Partial Administration" of the medication a number of times in a three month period.

The RPN indicated that the resident would instruct them to administer a smaller dose of their medication and that the physician had not been made aware that this occurred. The Physician's Assistant and Physician indicated that the resident had required increasing doses of the medication and if the resident was requesting lower doses of the medication, then they should be advised that this was occurring.

This increased the risk of harm to the resident as they were not receiving the doses of medication as prescribed by the physician to manage a medical diagnosis.

Sources: a resident's records including their EMARs, physical chart, and progress notes; the home's policy titled “Resident Rights, Care and Services - Medication Management - Administration of Medications including PRN medications” last revised June 30, 2020; interviews with an RPN, Physician's Assistant and Physician, and other relevant staff. [s. 131. (2)]

Issued on this 1st day of September, 2021

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) :	KEARA CRONIN (759), TIFFANY BOUCHER (543)
Inspection No. / No de l’inspection :	2021_901759_0005
Log No. / No de registre :	006270-21, 007154-21, 007990-21, 008078-21, 011095-21
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 24, 2021
Licensee / Titulaire de permis :	Orillia Long Term Care Centre Inc. c/o Jarlette Health Services, 711 Yonge Street, Midland, ON, L4R-2E1
LTC Home / Foyer de SLD :	Leacock Care Centre 25 Museum Drive, Orillia, ON, L3V-7T9
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Carrie Acton

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

To Orillia Long Term Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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 : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Order / Ordre :

The licensee must be compliant with s. 129. (1) of Ontario Regulation 79/10.

Specifically, the licensee must:

a) Ensure that drugs are stored in an area or medication cart that is secured and locked;
b) Conduct daily audits of all home areas to ensure that drugs are stored in an area or medication that cart is secured and locked;
c) Maintain documentation of the audits conducted, which should include: the name of the individual conducting the audit, the date of the audit, and the date and name of any drugs found in an area that is not secure and locked;
d) Conduct and document the audits until no further concerns are identified for at least a two week period.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were stored in an area or medication cart that was secured and locked.

a) A resident's Substitute Decision Maker (SDM) came to visit and found a medication left on the resident's bedside table. After review and investigation it was found that the medication was left at the beside after it was given to the resident.

An RN indicated that they put the medication down to take the resident's vital signs, left the room, and left the medication on the resident's table

b) An unattended medication cart was unlocked near the nursing station that also had two medications on top of the cart. There was a resident in the vicinity exiting the bathroom near the medication cart.

When an RPN Student returned they indicated that they forgot to lock the medication cart.

As a result, improper storage of the medications allowed for easy access by residents and there was actual risk of harm if the medications were accessed by residents.

Sources: Inspector #759's observations; a CI report; the homes investigation notes; the home's policies; interviews with an RN, RPN Student, and other relevant staff. [s. 129. (1) (a)]

An order was made by taking the following factors into account:

Severity: An actual risk was identified related to medications not being stored in an area or medication cart that was secured and locked as it allowed for the medications to be accessed by residents.

Scope: This non-compliance was identified as a pattern as there were two occurrences of medications that were not stored in an area or medication cart that was secured and locked.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with Ontario Regulation 79/10, s. 129. (1) and one VPC was issued to the home. (759)

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 : Sep 20, 2021

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:

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 24th day of August, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Keara Cronin

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