Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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 20, 2019	2019_556168_0013	014645-19, 014845-19	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Fox Ridge Care Community
389 West Street BRANTFORD ON N3R 3V9

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

LISA VINK (168), DARIA TRZOS (561), DIANNE BARSEVICH (581)

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): August 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, 29, 30, 2019 and September 3 and 4, 2019.

The following intakes were inspected during this Critical Incident System Inspection:
Log number 014645-19 - regarding medication management; and
Log number 014845-19 - regarding prevention of abuse and neglect.

Please note that the following inspections were completed concurrently with this Critical Incident System inspection:
Complaint Inspection, Inspection number 2019_556168_0012; and
Follow Up Inspection, Inspection number 2019_556168_0014.

Please note a voluntary plan of correction (VPC) related to Long Term Care Homes Act (LTCHA) section (s.) 6(2) related to plan of care, identified in a concurrent inspection Complaint Inspection, Inspection number 2019_556168_0012, was issued in this report.

Please note a VPC, related to LTCHA s. 6(10)b related to plan of care was identified in this inspection and has been issued in Complaint Inspection, Inspection number 2019_556168_0012, which was conducted concurrently with this inspection.

Please note a VPC, related to Ontario Regulation (O. Reg.) 79/10 s. 8(1)b related to policies etc. to be followed was identified in this inspection and has been issued in Follow Up Inspection, Inspection number 2019_556168_0014, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the acting Director of Care (aDOC), the Assistant Director of Care (ADOC), the Resident Assessment Instrument (RAI) Coordinator, the consultant pharmacist, a police officer, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Clinical Care Partner, the Nurse Practitioner (NP), the former Director of Care, the Resident Services Coordinator and residents.

During the course of the inspection, the inspectors observed the provision of care and services, observed medication administration and storage areas, reviewed documents including but not limited to incident reports, investigative notes, audits, relevant policies and procedures and resident clinical health records.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication
Pain
Personal Support Services

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

5 WN(s)
4 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. 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):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4); specifically a missing or unaccounted for controlled substance.

A review of the Long Term Care Homes portal was conducted to review Critical Incident Reports (CI), submitted from the long-term care home, to the Director, for missing or unaccounted for controlled substances.
It was identified that the home did not submit any CI reports, for missing or unaccounted for controlled substances, for the year of 2018 and only one CI report for 2019, for an incident, in July 2019.

A. Review of the Medication Incident Binder, for 2018, included an incident report on an identified date in April 2018, where a dose of a controlled substance was noted to be missing from the "bubble" or blister pack.
B. The home produced an email, on an identified date in April 2018, from RN #109 to the former DOC, which identified concerns with six missing tablets of a controlled substance.
C. A review of the Medication Incident Binder for 2019 included:
i. An incident report on an identified date in January 2019, where a controlled substance was "empty" when opened. The contents of the capsule were missing.
ii. An incident report on an identified date in April 2019, where during shift count it was noted that a controlled substance was missing from the "bubble" in the medication card.
iii. An incident report on another identified date in April 2019, where an identified resident's controlled substance could not be located.
iv. An incident report on an identified date in June 2019, where a controlled substance was "empty" when opened. The contents of the capsule were missing.

v. An incident report on an identified date in July 2019, where a controlled substance was "empty" when opened. The contents of the capsule were missing.

Interview with the Clinical Care Partner confirmed that based on their review, prior to the incident report submitted in July 2019, the home had not submitted a CI report to the Director for missing or unaccounted for controlled substances since 2013.
Interview with the former DOC, who worked at the home when the above noted incidents were identified, confirmed that the incidents were not reported to the Director and that this task was their responsibility. They identified that they did report the incidents to the Director as they felt the incidents were related to manufacturing and or dispensing issues and did not suspect diversion.

The Director was not informed of the missing or unaccounted for controlled substances.

Please note that this non compliance was identified during Critical Incident System Log number 014645-19. [s. 107. (3) 3.]

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the plans of care were based on an assessment of resident #009 and #019 and their needs and preferences related to pain management.

A. Resident #009 reported that they had experienced pain and was able to report the locations of the pain and causes.
A review of the clinical recorded included that they had an order for routine and as needed analgesics in an effort to manage their pain.
Interview with RN #108 confirmed that as a result of the pain, a care conference was held with the care team, which included the resident and the Medical Director to discuss how to best meet the needs and preferences of the resident related to pain management.

According to the Physician's Orders, on an identified date in May 2019, a conference was held where it was identified that a specified pain level was comfortable for the resident and could be managed.
A review of the clinical record identified that the resident frequently reported that they experienced pain at a specified level when routine analgesics were administered.
A review of the plan of care included a focus statement for the presence of the pain, the locations of the pain, what "makes their pain better" and to administer medications as ordered.
The plan of care did not include the resident's satisfactory pain level as identified by the resident as their preference, as confirmed by the Clinical Care Partner, following a review of the record.

B. According to the clinical record resident #019 reported that they experienced pain and was able to report the locations of the pain and causes.
A review of the clinical recorded included that they had an order for routine and as needed analgesics in an effort to manage their pain.
Interview with RN #108 confirmed that as a result of the pain, a care conference was held with the care team, which included the resident and the Medical Director to discuss how to best meet the needs and preferences of the resident related to pain management.

According to the Physician's Orders and a progress note, a conference was held, on an identified date in May 2019, where it was identified that a specified pain level was tolerable and the resident's goal was to keep their pain at that level. The orders identified that PSW staff were to communicate to registered staff when the resident requested a specified care so that analgesic could be administered, as able, in an effort to meet their

needs related to pain.
Interview with the acting DOC, following a review of the clinical record confirmed that the preference related to the resident's pain level goal was not included in the plan of care, with the exception of the identified progress note. It was also confirmed that direction for PSW staff in relation to actions to be taken prior to the specified care were not included in the care plan or kardex.
The acting DOC confirmed the expectation that the assessed needs and preferences of the resident, specifically related to pain management be included in the plan of care.

The plan of care was not based on an assessment of the resident and their needs and preferences.

Please note that these findings of non compliance were identified during Critical Incident System Log number 014645-19. [s. 6. (2)]

2. The licensee failed to ensure that the plan of care was based on an assessment of resident #020 and their needs and preferences related to bathing.

Review of the admission note identified resident #020's bathing preference was a specified method, on a specified shift.
A review of the written plan of care, from date of admission until an identified date in August 2019, indicated that the resident's preference was by the identified method and they required a level of care.
The care plan was reviewed and revised and indicated the resident's routine was one bath a week by one method and a second by another method.
Discussion with the ADOC identified that for identified reasons the resident was bathed by one method initially since admission and was not provided the preferred method until a device was made available in July 2019.
In an interview with resident #020 they stated their preference was to have bathing provided by one method only.
PSW #107, confirmed that since the device was available the resident was provided bathing by two different methods.
Interview with the ADOC, who updated the written plan of care, confirmed there was no reassessment of the resident, by the registered nursing staff, to determine the the resident's preference for the method of bathing.
Documentation reviewed identified that the resident was provided with bathing at the frequency of twice a week since admission.
The ADOC confirmed that the plan of care was not based on an assessment of the

resident and their needs and preferences.

The plan of care was not based on an assessment of the resident and their needs and preferences.

Please note that this non compliance was identified during Complaint Log number 016344-19. [s. 6. (2)]

3. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of residents #002, #004 and #010 so that their assessments related to pain were integrated, consistent with and complemented each other.

A. Resident #002 was identified on their Minimum Data Set (MDS) assessment, on an identified date in August 2019, that they experienced pain symptoms at a specified level.

A review of the clinical record during the seven day observation period for the assessment identified that the resident did not: receive any as needed analgesics; did not have any pain scores higher than a zero when routine analgesics were administered; nor were they assessed with a clinically appropriate pain assessment tool.
Interview with the Clinical Care Partner, following a review of the clinical record, confirmed that the MDS assessment was not accurate, based on the additional assessments completed during the observation period.
Interview with the RAI Coordinator identified that following a discussion with the Clinical Care Partner, they reviewed the assessments and confirmed that the assessments were not consistent with each other and as a result the MDS assessment was modified to reflect the symptoms of pain during the observation period.

B. Resident #004 had a MDS assessment, on an identified date in July 2019, which noted that they did not have pain symptoms during the observation period.
A review of the clinical record, during the seven day observation period, identified that the resident did not receive any as needed analgesic; however, had varied pain scores which identified the presence of pain when routine analgesics were administered and had a pain assessment which reported the presence of pain.
Interview with the Clinical Care Partner, following a review of the clinical record, confirmed that the MDS assessment was not consistent with the assessments completed during the observation period and that the MDS assessment was an error.

C. Resident #010 was identified on their MDS assessment, on an identified date in August 2019, that they experienced pain symptoms at the frequency of less than daily. A review of the clinical record during the seven day observation period for the assessment identified that the resident received as needed analgesics less than daily; however, reported pain at least once a day when routine analgesics were administered. Interview with the RAI Coordinator, following a review of the clinical record, confirmed that the resident reported pain at the frequency of at least daily as documented in the electronic Medication Administration Record for the seven day observation period and that the resident was identified in the MDS assessment as, complained of or demonstrated evidence of pain, less than daily.

The assessments of the resident were not integrated, consistent with and did not complement each other.

Please note that this non compliance was identified during Critical Incident System Log number 014645-19. [s. 6. (4) (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 the plan of care is based on an assessment of the resident and the resident's needs and preferences and to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee failed to ensure that drugs remained in the original labelled container or package provided by the pharmacy service provider until administered to a resident or destroyed.

A. RN #109 sent an email to the DOC, on an identified date in April 2018, regarding medications.
The email identified that when RN #109 completed the narcotic count they noted that there were two empty spaces in a card which were to contain a controlled substance for a specified resident. RN #131 was informed of the concern and produced the capsules, which they reported they found in a medication cup. RN #109 continued to report that during the same narcotic count they then noted four missing spaces [in a narcotic card] which was to contain a controlled substance. RN #131 was again notified of the concern, made a statement, left the area and returned with a specified quantity (ten), of a controlled substances in two different dosages.
RN #131 was not available to be interviewed during the inspection.
RN #109 confirmed that the medications were not in their original labelled packaging when they were given to them on the identified date in 2018, by RN #131.

B. Observation of a medication cart on an identified date in August 2019, noted a medication for resident #021, which was not in the original labelled container or package provided by the pharmacy.
The medication was dispensed in perforated blister packs from the pharmacy.
As observed in the medication cart, the blister packs had been separated into individual dosage sized squares, removed from from their original packaging and stored in the medication cart.
RN #132 confirmed that the medication did not contain a label which identified the resident's name or physician's order, nor was it stored in the original package.

Not all drugs remained in the original labelled container or package provided by the pharmacy service provider until administered to a resident or destroyed.

Please note that this non compliance was identified during Critical Incident System Log number 014645-19. [s. 126.]

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 drugs remain in the original labelled container or package provided by the pharmacy service provider until they are administered to a resident or destroyed, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where drugs were stored were restricted to persons who could dispense, prescribe or administer drugs in the home and the Administrator.

On an identified date in August 2019, a key ring which contained a large number of keys was located in an unsecured location in the home.
This key ring included a key to a specified medication room, which stored medications.
The key was not secured, was accessible and was not restricted to persons who may dispense, prescribe or administer drugs in the home and the Administrator.
The key was provided to the acting DOC and Clinical Care Partner by the Inspector.
The acting DOC was able to access the medication room door with the key, confirmed that it should not have been kept at the nursing station and communicated plans to remove the key immediately.
Discussion with RN #109 on an identified date in September 2019, identified that the key was now maintained in a secured location.

Not all areas where drugs were stored were restricted to persons who could dispense, prescribe or administer drugs in the home and the Administrator.

Please note that this non compliance was identified during Critical Incident System Log number 014645-19. [s. 130. 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 all areas where drugs are stored are restricted to persons who could dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #5: 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. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all medication incidents were documented, reviewed and analyzed and corrective action was taken as necessary, and a written record was kept of everything required.

O. Reg. 79/10 described a "medication incident" as a preventable event associated with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a prescription, and includes,
(a) an act of omission or commission, whether or not it results in harm, injury or death to a resident, or
(b) a near miss event where an incident does not reach a resident but had it done so, harm, injury or death could have resulted.

An email from RN #109, to the former DOC, on a specified date in April 2018, identified specific concerns with the storage of controlled substances in the home, specifically: for resident #022, a controlled substance in two different dosages and the location of other controlled substances which were unknown if they were prescribed for a resident.
A subsequent email, sent the same day, from RN #109 to the former DOC, identified potential concerns with how another controlled substance was dispensed and appeared to be missing for resident #024.
A review of the Medication Incident Binder, for 2018, did not include incident reports for the identified concerns.
A review of the Medication Incidents [Summary], for April 2018, did not include the incidents as noted in the emails from April 2018.
Interview with the Community Care Partner, following a review of the medication incident reports and a discussion with the pharmacist confirmed that the medication incidents were not documented and for this reason not reviewed and analyzed and any correction action that might had been taken, by the former DOC, was not documented.
Interview with the former DOC, who worked at the home in April 2018, was not able to recall the concerns, the email correspondence nor any actions taken as a result.
Interview with RN #109 identified that they were not questioned nor did they receive additional information regarding the emails in 2018.

Not all all medication incidents were documented, reviewed and analyzed, nor if corrective action was taken was a record maintained.

Please note that this non compliance was identified during Critical Incident System Log number 014645-19. [s. 135. (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 all medication incidents are documented, reviewed and analyzed and corrective action is taken as necessary and a written record is kept of everything as required, to be implemented voluntarily.

Issued on this 25th day of September, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA VINK (168), DARIA TRZOS (561), DIANNE BARSEVICH (581)
Inspection No. / No de l'inspection :	2019_556168_0013
Log No. / No de registre :	014645-19, 014845-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 20, 2019
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Fox Ridge Care Community 389 West Street, BRANTFORD, ON, N3R-3V9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sandy Croley

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
   i. a breakdown or failure of the security system,
   ii. a breakdown of major equipment or a system in the home,
   iii. a loss of essential services, or
   iv. flooding.
3. A missing or unaccounted for controlled substance.
4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Order / Ordre :

The licensee must be compliant with s. 107(3) of Ontario Regulation 79/10.

Specifically, the licensee must:
1. Ensure that the Director is informed, of a missing or unaccounted for controlled substance, in the home no later than one business day after the occurrence of the incident, followed by a report required.
2. All staff, who have the responsibility, as determined by the licensee, to notify the Director of Critical Incident Reports, by reporting through Service Ontario After Hours line or the Critical Incident Reporting system, shall be provided education on the expectations for and the process to report an occurrence to the Director of a missing or unaccounted for controlled substance as well as the time frames for reporting.
3. All missing or unaccounted for controlled substances, in the home, shall be reported at the morning management meeting, by the Director of Care or designate and actions taken to date shall be discussed, including the reporting of the incident to the Director. These meetings shall be documented and the records shall include the incident(s) of the missing or unaccounted for controlled substance(s) and when the Director was or is to be notified. The records shall be maintained in the home.

Grounds / Motifs :

1. The licensee failed to ensure that the Director was informed of incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4); specifically a missing or unaccounted for controlled substance.

A review of the Long Term Care Homes portal was conducted to review Critical Incident Reports (CI), submitted from the long-term care home, to the Director, for missing or unaccounted for controlled substances.
It was identified that the home did not submit any CI reports, for missing or unaccounted for controlled substances, for the year of 2018 and only one CI report for 2019, for an incident, in July 2019.

A. Review of the Medication Incident Binder for 2018 included an incident report on an identified date in April 2018, where a dose of a controlled substance was noted to be missing from the "bubble" or blister pack.
B. The home produced an email, on an identified date in April 2018, from RN

#109 to the former DOC, which identified concerns with six missing tablets of a controlled substance.
C. A review of the Medication Incident Binder for 2019 included:
i. An incident report on an identified date in January 2019, where a controlled substance was "empty" when opened. The contents of the capsule were missing.
ii. An incident report on an identified date in April 2019, where during shift count it was noted that a controlled substance was missing from the "bubble" in the medication card.
iii. An incident report on another identified date in April 2019, where an identified resident's controlled substance could not be located.
iv. An incident report on an identified date in June 2019, where a controlled substance was "empty" when opened. The contents of the capsule were missing.
v. An incident report on an identified date in July 2019, where a controlled substance was "empty" when opened. The contents of the capsule were missing.

Interview with the Clinical Care Partner confirmed that based on their review, prior to the incident report submitted in July 2019, the home had not submitted a CI report to the Director for missing or unaccounted for controlled substances since 2013.
Interview with the former DOC, who worked at the home when the above noted incidents were identified, confirmed that the incidents were not reported to the Director and that this task was their responsibility. They identified that they did report the incidents to the Director as they felt the incidents were related to manufacturing and or dispensing issues and did not suspect diversion.

The Director was not informed of the missing or unaccounted for controlled substances.

Please note that this non compliance was identified during Critical Incident System Log number 014645-19.
The severity of this issue was determined to be a level 2, minimum harm or risk.
The scope of the issue was determined to be a level 3, widespread.
The home had a level 2 compliance history as they had previous non-compliance to a different subsection.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

(168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 31, 2019

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 Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, 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 Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS 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 de la Santé et 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 de la Santé et 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 20th day of September, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LISA VINK

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