Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 10, 15, 2017	2017_491647_0017	023477-17	Resident Quality Inspection

Licensee/Titulaire de permis

2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP
302 Town Centre Blvd. Suite #200 MARKHAM ON L3R 0E8

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

Muskoka Shores Care Community
200 KELLY DRIVE GRAVENHURST ON P1P 1P3

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

JENNIFER BROWN (647), VALERIE PIMENTEL (557)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 12, 13, 16, 17, 18, 19, and 23, 2017.

The following critical incidents (CI) were inspected concurrently with this inspection:
005038-17: related to a fall with injury,
012027-17: related to a fall with injury,
015020-17: related to a fall with injury,
001436-17: related to administration of medication,

The following follow up to existing compliance orders was inspected concurrently with this inspection:
002825-17: related to a compliance order issued to the licensee for s. 3(1) and r. 131.(2) on October 21, 2016, during inspection 2016_433625_0004.
002826-17: related to a compliance order issued to the licensee for s.20(1) on October 21, 2016, during inspection 2016_433625_0005,
034749-16: related to a compliance order issued to the licensee for s.6(7) on December 13, 2016, during inspection 2016_514566_0017,
006886-17: related to a compliance order issued to the licensee for s.6(7) on March 3, 2017, during inspection 2016_535557_0016.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, Family Members, Power of Attorney (POA), and Substitute Decision Makers (SDM).

During the course of the inspection, the inspectors conducted observation in home and residents' areas, observation of care delivery processes including medication passes and meal delivery services, and review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 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	2016_433625_0004	647
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #001	2016_433625_0005	647
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2016_433625_0004	647
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2016_535557_0016	647
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2016_514566_0017	647

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	Legendé 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. 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 are administered to residents in accordance with the directions for use specified by the prescriber.

During the Resident Quality Inspection (RQI), the home's medication and adverse drug reaction incident reports for a three month period of time were reviewed.

1) On an identified date, a medication incident report was completed for resident #008, confirming the administration of the identified medication, route of administration and time of administration. Resident #008 was to receive the identified medication at an identified time. Review of the Narcotic and Controlled Drug Administration Record (NCDAR) for an identified date, confirmed the identified medication was administered at the identified time by Registered staff member #119 to resident #008.

An interview with Registered staff member #119 confirmed he/she did administer the identified medication and dose instead of the prescribed dose of the identified medication to resident #008. He/she further revealed he/she took the identified medication from the wrong blister pack belonging to another resident. He/she identified the physician was informed and instructed the staff to monitor the resident.

2) On an identified date, a medication incident report was completed for resident #026, confirming the administration of an identified medication, route of administration and time of administration. Resident #026 was to receive the identified medication during an identified shift. Review of the electronic Medication Administration Record (EMAR) for an identified date, confirmed the administration of the identified medication by Registered staff member #125.

An interview with the Director of Care (DOC) confirmed Registered staff member #125 did administer the identified medication instead of the prescribed amount of the identified medication to resident #026.

He/she further revealed Registered staff member #026 took the identified medication from the wrong blister pack for the identified resident.

3) On an identified date, a medication incident report was completed for resident #025, confirming the administration of an identified medication, route of medication and time of administration. Resident #025 was to receive the identified medication at an identified time. Review of the Monitored Medication Record for 7-Day Card (MMR7DC) for an identified date, confirmed an identified medication was administered at an identified time by Registered staff member #119.

An interview with Registered staff member #119 confirmed he/she administered an identified medication instead of the prescribed amount of an identified medication to resident #025. He/she further revealed the identified medication had been taken from the wrong blister pack that belonged to another identified resident. He/she identified the physician was informed and instructed the staff to monitor the resident's vital signs until the following day and to hold the following dose of the identified medication.

Interview with the Assistant Director of Care (ADOC) and DOC confirmed he/she met with the identified registered staff members and reviewed the medication errors with them and provided education. The ADOC and DOC confirmed it is the home's expectation that medications are administered as prescribed to all residents with in the home.

4) Review of the following Log # 001436-17, a critical incident (CI) had been submitted on an identified date, revealed resident #024 may have received the wrong dose of an identified medication.

The CI identified the identified container containing an identified medication was opened on an identified date. The order was to administer an identified amount which equaled an identified amount, identified route of administration and an identified frequency of administration. The resident was administered 24 doses over the 12 day period which accounted for an identified amount. There was an identified amount of medication missing.

On an identified date, Registered staff member #123 revealed he/she went to see why resident #024 did not attend breakfast that morning. Registered staff member #123 confirmed the resident did not respond to them when he/she called their name. Registered staff member #123 then called Registered staff member #117 for assistance. After an assessment by the Nurse Practitioner (NP) and discussion with the physician, resident #024 was sent to the hospital for further assessment. The resident returned three hours later, the hospital discharge report indicated that it was it was unclear that an adverse reaction had occurred.

Interview with the DOC revealed he/she was not involved with this particular medication incident but had knowledge of the incident. He/she confirmed the home concluded resident #024 did receive extra identified medication administered by Registered staff member #127 and confirmed there was then an identified amount missing from the prescription container. The DOC identified it is the homes expectation that medications are administered to the residents in accordance with the directions for use specified by

the prescriber.

A compliance order will be served to the home based on the scope, which is a pattern, the severity of the non-compliance was minimal harm and or potential harm, and the home had previously been issued a voluntary plan of correction (VPC) as part of inspection 2015_297558_0015 on August 19, 2015 and also as part of inspection 2016_433625_0004 on October 21, 2016, for this legislation. [s. 131. (2)]

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 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.

The home submitted a CI, on an identified date, which had indicated that there had been an incident that caused injury to resident #009 for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

A review of the above mentioned CI indicated that resident #009 had been found on the floor with an upper body injury. Resident #009 had been unable to get up from the floor him/herself.

A record review of the progress notes indicated that on an identified date, resident #009 had lost his/her balance, fell, and resulted in no injuries. The record review further indicated that resident #009 fell again on an identified date, and sustained upper body injuries and had been required to be sent to hospital for treatment.

A clinical record review indicated that resident had not been assessed after the falls on the identified dates, relating to health status changes, mobility changes or transferring status changes.

A further clinical review of the written plan of care for resident #009 indicated that there had not been a reassessment, review or revision of the plan of care after resident #009 fell on the identified dates.

Registered staff members #108 and #103 indicated during an interview that after the first two falls mentioned above, resident #009 should have been assessed for causal factors and the plan of care reviewed and revised accordingly. After review of the plan of care by the above mentioned staff, it had been acknowledged that resident #009's plan of care had not been reassessed, reviewed or revised after his/her falls on the identified dates.

The above mentioned staff further indicated that if the resident had been assessed after the first two incidents there may have been effective interventions put into place to avoid the third incident on the identified date.

Interview with ADOC #111 acknowledged that resident #009 did not have his/her plan of care reassessed, reviewed or revised after the falls on the identified dates and further confirmed that all plans of care are expected to be reassessed, reviewed and revised at any time where the resident's care needs change or are no long necessary in order to reassess, review and revise current interventions to mitigate the risk of fall and fall with injury. [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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place was complied with.

Under O.Reg 79/10, s. 114 (1) (2), written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Policy 1:
Record review of Medical Pharmacies policy, titled: "Individual Monitored Medication Record", policy number 6.5, last review date of February 2017, identified the registered staff are to sign the individual monitored medication record each time a dose is administered including date, time, amount given, amount wasted and new quantity

remaining.

The inspector observed while reviewing resident #026's medication incident report for the administration of an identified medication, that Registered staff member #119 had not signed the individual monitored medication record on an identified date, at the time he/she administered the medication and blister number 21 line remained blank on the Individual Monitored Medication record.

Interview with Registered staff member #119 confirmed he/she did administer the identified medication resident #026 on the identified date, and confirmed he/she did not sign the above identified record at the time of administration as directed by the home's policy.

Interview with the DOC confirmed Registered staff member #109 did not sign the above identified record at the time of administration as directed by the home's policy.

Policy 2:
Record review of Medical Pharmacies policy, titled: "Medication Incident Reporting", policy number 9.1, last review date of February 2017, every medication incident and adverse drug reaction involving a resident (excluding near miss) is to be reported to the resident or the resident's substitute decision maker, the DOC, the attending physician and the clinical pharmacist.

Review of the home's medication incident report for resident #026 identified he/she received an incorrect dose of identified medication. During the review of medication incident reports, the inspector noted resident #026's substitute decision maker (SDM) and physician were not notified of the identified medication incident.

Interview with the DOC confirmed the home did not notify resident #025's SDM or physician at the time of the medication incident and the home did not comply with the policy. [s. 8. (1) (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 any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Record review of the annual evaluation of the medication management system for an identified year, revealed the Medical Director (MD), pharmacist and registered dietitian did not participate in the annual review of the homes medication system.

An interview with the DOC confirmed the MD, pharmacist and registered dietitian did not participate in the annual review. [s. 115. (1)]

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. (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 every medication incident involving a resident and every adverse drug reaction is 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.

Record review of three high risk medication incident reports from a three month period of time, were reviewed and revealed the following:
-Medication incident on an identified date, indicated the resident or SDM had not been notified
-Medication incident on an identified date, indicated the Medical Director (MD), attending physician or the registered nurse in the extended class attending the resident had not been notified.

An interview with the DOC confirmed it is an expectation that every medication incident involving a resident and every adverse drug reaction is reported to the resident or the resident's substitute decision-maker and the MD, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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Issued on this 23rd day of November, 2017

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

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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) :	JENNIFER BROWN (647), VALERIE PIMENTEL (557)
Inspection No. / No de l'inspection :	2017_491647_0017
Log No. / No de registre :	023477-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 10, 15, 2017
Licensee / Titulaire de permis :	2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP 302 Town Centre Blvd., Suite #200, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Muskoka Shores Care Community 200 KELLY DRIVE, GRAVENHURST, ON, P1P-1P3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Angela Coutts

To 2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 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

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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. 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 :

Within 10 days upon receipt of this order the licensee shall:

1. The licensee shall provide a plan to the inspector on how the home will educate staff relating to drugs that are administered to residents in accordance with the directions for use as specified by the precriber and review dosage calculations for liquid drugs with all registered nursing staff.

2. The plan must also include how staff will be educated, including staff on MAT leave, medical leave, etc. when they return to work on the home's plan as mentioned in step 1.

3. The plan must also include a review of the home's pharmacy policies and procedures related to medication administration in order to meet the requirements of the Long Term Care Act and Regulations and to review the home's interdisciplinary medication management system that provides safe medication management to the residents.

4. The plan must also include how staff will be educated, on the home's plan as mentioned in step 1.

5. Minutes of the policy review and attendance of the required staff education to be documented and maintained.

6. The plan(s) shall include time lines and the name of the person(s) responsible for completing the tasks and the time lines for completion. The plan shall be submitted on or before December 29, 2017, to jennifer.brown6@ontario.ca.

Grounds / Motifs :

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

During the Resident Quality Inspection (RQI), the home's medication and adverse drug reaction incident reports for a three month period of time were reviewed.

1) On an identified date, a medication incident report was completed for resident #008, confirming the administration of the identified medication, route of administration and time of administration. Resident #008 was to receive the identified medication at an identified time. Review of the Narcotic and Controlled Drug Administration Record (NCDAR) for an identified date, confirmed the identified medication was administered at the identified time by Registered staff member #119 to resident #008.

An interview with Registered staff member #119 confirmed he/she did administer the identified medication and dose instead of the prescribed dose of the identified medication to resident #008. He/she further revealed he/she took the identified medication from the wrong blister pack belonging to another resident. He/she identified the physician was informed and instructed the staff to monitor the resident.

2) On an identified date, a medication incident report was completed for resident #026, confirming the administration of an identified medication, route of administration and time of administration. Resident #026 was to receive the identified medication during an identified shift. Review of the electronic Medication Administration Record (EMAR) for an identified date, confirmed the administration of the identified medication by Registered staff member #125.

An interview with the Director of Care (DOC) confirmed Registered staff member #125 did administer the identified medication instead of the prescribed amount of the identified medication to resident #026. He/she further revealed Registered staff member #026 took the identified medication from the wrong blister pack for the identified resident.

3) On an identified date, a medication incident report was completed for resident

#025, confirming the administration of an identified medication, route of medication and time of administration. Resident #025 was to receive the identified medication at an identified time. Review of the Monitored Medication Record for 7-Day Card (MMR7DC) for an identified date, confirmed an identified medication was administered at an identified time
by Registered staff member #119.

An interview with Registered staff member #119 confirmed he/she administered an identified medication instead of the prescribed amount of an identified medication to resident #025. He/she further revealed the identified medication had been taken from the wrong blister pack that belonged to another identified resident. He/she identified the physician was informed and instructed the staff to monitor the resident's vital signs until the following day and to hold the following dose of the identified medication.

Interview with the Assistant Director of Care (ADOC) and DOC confirmed he/she met with the identified registered staff members and reviewed the medication errors with them and provided education. The ADOC and DOC confirmed it is the home's expectation that medications are administered as prescribed to all residents with in the
home.

4) Review of the following Log # 001436-17, a critical incident (CI) had been submitted on an identified date, revealed resident #024 may have received the wrong dose of an identified medication. The CI identified the identified container containing an identified medication was opened on an identified date. The order was to administer an identified amount which equaled an identified amount, identified route of administration and an identified frequency of administration. The resident was administered 24 doses over the 12 day period which accounted for an identified amount. There was an identified amount of medication missing. On an identified date, Registered staff member #123 revealed he/she went to see why resident #024 did not attend breakfast that morning. Registered staff member #123 confirmed the resident did not respond to them when he/she called their name.

Registered staff member #123 then called Registered staff member #117 for assistance. After an assessment by the Nurse Practitioner (NP) and discussion with the physician, resident #024 was sent to the hospital for further assessment. The resident returned three hours later, the hospital discharge

report indicated that it was it was unclear that an adverse reaction had occurred.

Interview with the DOC revealed he/she was not involved with this particular medication incident but had knowledge of the incident. He/she confirmed the home concluded resident #024 did receive extra identified medication administered by Registered staff member #127 and confirmed there was then an identified amount missing from the prescription container. The DOC identified it is the homes expectation that medications
are administered to the residents in accordance with the directions for use specified by the prescriber.

A compliance order will be served to the home based on the scope, which is a pattern, the severity of the non-compliance was minimal harm and or potential harm, and the home had previously been issued a voluntary plan of correction (VPC) as part of inspection 2015_297558_0015 on August 19, 2015 and also as part of inspection 2016_433625_0004 on October 21, 2016, for this legislation. [s. 131. (2)] (557)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 10th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : Jennifer Brown

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