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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Jan 29, 2020	2020_587129_0001	023705-19, 000162-20	Complaint

Licensee/Titulaire de permis

Liuna Local 837 Nursing Home (Hamilton) Corporation
44 Hughson Street South HAMILTON ON L8N 2A7

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

Queen's Garden
80 Queen Street North HAMILTON ON L8R 3P6

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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 8, 9, 10, 13, 16, 17, 20, 21, 22, 2020.

The following Intakes were inspected:
000162-20 related to skin and wound care, pain management and medication administration.
023705-19 related to wound care supplies/personal care supplies/linen supplies and Director of Care hours.

During the course of the inspection, the inspector(s) spoke with resident family members, Personal Support Workers, Registered Practical Nurses, Registered Nurses, Charge Nurse, Resident Assessment Instrument Coordinator, Laundry Aide, Restorative Aide, Wound Care Nurse, Environmental Services Manager and the Administrator.

During the course of this inspection the Inspector reviewed resident's clinical records, policies and procedures, training records, supply invoices, supply management practices and made observations of supplies available in the home.

The following Inspection Protocols were used during this inspection:
Pain
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
6 WN(s)
6 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other, in the development and implementation of the plan of care so that the different aspects of the care are integrated and are consist with and complement each other.

Registered staff did not collaborate with the Pharmacist, in the development and implementation of resident #001's plan of care related to the administration of a medication.

On an identified date, an order was written for resident #001 to receive an identified drug, twice a day for 14 days. This medication order was electronically sent to the Pharmacy and on the same day the Pharmacist forwarded a letter to the attention of a home area Charge Nurse. The letter contained an alert for staff in relation to the administration of the identified drug. The clinical record indicated there had not been communication between registered nursing staff and the Pharmacist, with respect to the administration alert sent by the Pharmacist.

A review of the Medication Administration Record (MAR) being used at this time indicated that the specific administration alert sent by the Pharmacist had not been entered on the MAR. The above noted MAR confirmed that resident #001 received this medication initially at 2030 hours on an identified date, and then at 0800 hours and 2030

for the next four days.

During a discussion with Registered Practical Nurse (RPN) #101 and the Resident Assessment Instrument (RAI) Coordinator, they indicated that the alert letter from the Pharmacist would have been received by registered staff who would normally place correspondence from the Pharmacist in the Physician's book for the Physician to review. Both of the above noted staff indicated they were not aware of the Pharmacist's alert related to the administration of the identified drug.

Registered staff did not collaborate with the Pharmacist in the development and implementation of the plan of care when a medication administration alert sent by the Pharmacist was not included in the directions for registered staff related to the safe administration of the above noted drug. [s. 6. (4) (b)]

2. The licensee failed to ensure that the resident's substitute decision-maker was given the opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #001's Substitute Decision-Marker (SDM) was not given the opportunity to fully participate in the development and implementation of the resident's plan of care, specifically related to medication administration.

The most current Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessment completed for resident #001 on an identified date, indicated the resident experienced a cognitive impairment.

A review of the clinical record indicated on an identified date, the resident's SDM provided a letter to the home which contained a request that they be notified of any proposed changes in medications for resident #001.

During a discussion with RPN #101, and a review of the clinical record it was identified that registered staff had not contacted resident #001's SDM prior to the resident receiving two new medications on identified dates.

Resident #001's SDM was not given the opportunity to participate fully in the development and implantation of the resident's plan of care when they were not contacted prior to the administration of two new medications to the resident. [s. 6. (5)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the resident's substitute decision maker is given the opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #2: 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 failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy or procedure, that the policy or procedure were complied with.

a) In accordance with O. Reg. s. 48 (1) 2, the licensee shall ensure there is an interdisciplinary skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers and provide effective skin and wound care interventions.

In accordance with O. Reg. s. 30 (1) 1, the licensee is to ensure that for each of the interdisciplinary programs required under section 48 of this Regulation, there must be written descriptions of the program that includes its goals and objectives and relevant policies.

The licensee failed to ensure their policy; "Skin Care Program Overview", identified as LTC-CA-WQ-200-08-01, with a revised date of December 2019 and their policy; "Wound Care Treatment", identified as LTC-CA-WQ-200-08-03, with a revision date of December 2017, was complied with.

i) The licensee's policy "Skin Care Program Overview", identified above, directed; registered staff will complete a skin assessment using the SKIN - Initial Skin and Wound assessment in the computerized clinical record, with any newly identified alteration in skin integrity.

Registered staff failed to comply with this direction when on an identified date, RPN #104 documented in the clinical record that resident #001 demonstrated an alteration in their skin integrity. Four days later the resident was seen by a Nurse Practitioner (NP) and treatment for the area was initiated.

RPN #101 and the clinical record confirmed that a SKIN - Initial Skin and Wound assessment was not completed when this newly identified alteration in skin integrity was noted.

ii) The licensee's policy "Wound Care Treatment", identified above, directed: registered staff are responsible to create and maintain a current resident care plan that reflects:
-the current status, location and type of alteration,
-risk factors present for skin breakdown,
-preventative measures to be taken to protect skin integrity,
-interventions undertaken to address alterations in skin integrity to promote healing, and
-interventions related to pain management.

Registered staff failed to comply with this direction when it was identified that resident #001 experience altered skin integrity and a care plan was not created.

RPN #101 reviewed resident #001's care plan and confirmed that a care plan related changes in the integrity of resident #001's skin had not been developed when this change was noted and documented in the clinical record.

The licensee failed to ensure that their Skin and Wound policies were complied with when it was identified that resident #001 experienced an alteration in their skin integrity.

b) In accordance with O. Reg. s. 48 (1) 4, the licensee shall ensure there is an interdisciplinary pain management program to identify pain in residents and manage pain.

In accordance with O. Reg. s. 30 (1) 1, the licensee is to ensure that for each of the interdisciplinary programs required under section 48 of this Regulation - there must be written descriptions of the program that includes its goals and objectives and relevant policies.

The licensee failed to ensure their policy "Pain and Palliative Care", identified a LTC-CA-WQ-200-05-04, with a revised date of December 2019, was complied with.

The above noted policy directed; Staff will complete a new Comprehensive Pain Assessment Tool when a resident reports new pain that is not episodic in nature, such as a headache, or an exacerbation of exiting pain that is not easily addressed with medication adjustment.

RPN #101 and resident #001's clinical record confirmed that a Comprehensive Pain Assessment was not completed when it was identified and documented that resident #001 experienced pain related to an altercation in the integrity of their skin. [s. 8. (1) (a),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 and ensuring that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy or procedure, that the policy or procedure was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of health conditions, including pain.

Resident #001's plan of care was not based on an interdisciplinary assessment of pain the resident experienced.

Registered staff first became aware that resident #001 experienced pain on an identified date, when RPN #103 made a clinical note which indicated the resident experienced plan related to an area of altered skin integrity.

Four days after staff initially documented the resident experienced pain, a clinical note indicated that the resident continued to experience pain related to the area of altered skin integrity.

Fifteen days later, RPN #101 documented that the resident reported they experienced pain related to the same area of altered skin integrity. On the same day, RPN#101 documented they had contacted the NP related to the pain and later that day RPN #105 made a clinical note that indicated, an identified drug was started as per doctor's order related to pain the resident experienced around the area of altered skin integrity.

During a discussion and a review of the clinical record, at the time of this inspection, RPN #101 confirmed that resident #001's plan of care was not based on a pain assessment, because a pain assessment had not been completed during the above noted period of time.

The interdisciplinary team did not ensure resident #001's plan of care was based on an assessment of pain the resident experienced. [s. 26. (3) 10.]

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 and ensuring that the plan of care is based on, at a minimum, interdisciplinary assessment of health conditions, including pain, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment and received immediate treatment and interventions to reduce or relieve pain, promote healing, as required.

a) Resident #001 did not receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument.

On an identified date, registered staff were alerted to, and documented in the clinical record that the resident #001 had an area of altered skin integrity on an identified body part, the area seemed infected, appeared red and the resident experienced pain when the area was touched and under other circumstances.

A review of the clinical record confirmed a dietary referral for skin alteration had been completed by the Registered Dietitian on an identified date related to the above noted area of altered skin integrity.

Three days later, registered staff documented two clinical notes. The first note made at 1534 hours indicated the resident was seen by the Nurse Practitioner who ordered medication for the resident related to suspected wound infection over the area of altered skin integrity. The second note made at 1707 hours indicated the resident had a suspected wound type of infection with symptoms that included redness over the area of altered skin integrity and the area was noted to be painful.

The clinical record, RPN #101 and the RAI Coordinator confirmed that a skin and wound assessment, using a clinically appropriate assessment instrument had not been completed when the above noted condition was identified.

b) Resident #001 did not receive immediate treatment and interventions to reduce or relieve pain or promote healing when staff documented in the clinical record that the resident had an area of altered skin integrity that was painful.

A review of resident #001's Medication Administration Record (MAR), over the above noted period of time, indicated that the resident's physician had ordered two, as necessary, medications for pain; however neither of these medications were administered to the resident when staff documented they were aware the resident experienced pain over a 20 day period of time.

Antibiotic therapy was not initiated for four days after it was identified that the resident appeared to have an infection related to an area of altered skin integrity.
A review of the resident's plan of care confirmed that care plan focuses related to the resident's altered skin integrity, infection, and pain were not established and there were no care interventions related to the management of these issues.

RPN #101 confirmed that resident #001 did not receive immediate treatment for the

altered skin integrity issue, pain associated with this issue or management of infection related to this issue. [s. 50. (2) (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 and ensuring that a resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and receives immediate treatment and interventions to reduce or relieve pain, promote healing, as required, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to the residents received, as a condition of continuing to have contact with residents, training in other areas provided for in the regulations.

In accordance with O. Reg. 221(1) 2, training in the area of skin and wound care is an area in which annual training shall be provided to all staff who provide direct care to residents.

The licensee failed to ensure all staff who provided direct care to residents in 2019, received training in the area of skin and wound care.

Training records provided by the Administrator at the time of this inspection indicated that 19.8% (24 of 121) of staff who provided direct care to residents had not received training in the area of skin and wound care in 2019. [s. 76. (7) 6.]

2. The licensee failed to ensure that all staff who provided direct care to the residents received, as a condition of continuing to have contact with residents, training in other areas provided for in the regulations.

In accordance with O. Reg. 221(1) 4, training in the area of pain management, including pain recognition of specific and non-specific signs of pain, is an area in which annual training shall be provided to all staff who provide direct care to residents

The licensee failed to ensure all staff who provided direct care to residents in 2019, received training in the area of pain management, including pain recognition of specific and non-specific signs of pain.

Training records provided by the Administrator at the time of this inspection indicated that 19% (23 of 121) of staff who provided direct care to residents had not received training in the area of pain management in 2019. [s. 76. (7) 6.]

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 and ensuring that all staff who provided direct care to the residents received, as a condition of continuing to have contact with residents, training in other areas provided for in the regulations, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's Director of Nursing and Personal Care worked regularly in that position on site at the home, at least 35 hours per week.

In accordance with O. Reg. 79/10, s. 213(1) 5, in a home with a licensee bed capacity of 80 beds or more, the Director of Nursing and Personal Care works regularly in that position on site at the home, at least 35 hours per week.

Queens Garden is a long-term care home with a 128 licensed bed capacity.

The Administrator verified that the previous Director of Care (DOC) left their employment on Friday December 6, 2019, and provided documentation to indicate the following:
-For the week starting December 9, 2019, a RN Nurse Consultant and a DOC from a related home provided DOC support for a total of 24 hours that week.
-For the week starting December 23, 2019, DOC support was provided by Registered Nurses (RNs) who were part of the regularly scheduled RN coverage for the home.
-For the week starting December 30, 2019, DOC support was provided by Registered Nurses (RNs) who were part of the regularly scheduled RN coverage for the home.
-For the week starting January 6, 2020, DOC support was provided by three DOCs from related homes and a RN Nurse Consultant, for a total of 32 hours that week.

The Administrator indicated that some of the duties assigned to a DOC would have been completed by the above noted individuals.

During an interview with RN #114, the RN work schedule that began on January 6, 2019, was reviewed and it was verified that all RNs working their regularly scheduled shifts would have been responsible to discharge their duties according to their determined work routines and they would not have had many opportunities to complete the work of the DOC while completing their regular duties.

RN #114 confirmed that a RN had not been assigned to act as the DOC and the work schedule noted above confirmed that there was not an additional RN scheduled to work during the above noted period of time.

The licensee did not ensure a person was assigned to work regularly in the role of DOC for at least 35 hours a week between December 9, 2019 and January 10, 2020. [s. 213. (1) 5.]

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 and ensuring at the home's Director of Nursing and Personal Care worked regularly in that position on site at the home, at least 35 hours per week., to be implemented voluntarily.

Issued on this 4th day of February, 2020

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

Original report signed by the inspector.

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : PHYLLIS HILTZ-BONTJE (129)

Inspection No. / No de l'inspection : 2020_587129_0001

Log No. / No de registre : 023705-19, 000162-20

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Jan 29, 2020

Licensee / Titulaire de permis : Liuna Local 837 Nursing Home (Hamilton) Corporation
44 Hughson Street South, HAMILTON, ON, L8N-2A7

LTC Home / Foyer de SLD : Queen's Garden
80 Queen Street North, HAMILTON, ON, L8R-3P6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Lorraine Koop

To Liuna Local 837 Nursing Home (Hamilton) Corporation, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (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
(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).

Order / Ordre :

The licensee must be compliant with s.6 (4)(b) of the LTCHA.

Specifically the licensee must:

Implement a process to ensure that all verbal and written communication from the Pharmacist, related to the administration of medications to residents is reviewed by registered nursing staff and included in the development of the resident's plan of care.

Grounds / Motifs :

1. The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of the care are integrated and are consist with and complement each other.

Registered staff did not collaborate with the Pharmacist in the administration of a medication to resident #001.

On an identified date, an order was written for resident #001 to receive an identified drug, twice a day for 14 days. This medication order was electronically sent to the Pharmacy and on the same day the Pharmacist forwarded a letter to the attention of a home area Charge Nurse. The letter contained an alert to staff

in relation to the administration of the identified drug. The clinical record indicated there had not been communication between the registered nursing staff and the Pharmacist, with respect to the administration alert sent by the Pharmacist.

A review of the Medication Administration Record (MAR) being used at this time indicated that the specific administration alert sent by the Pharmacist had not been entered on the MAR. The above noted MAR confirmed that resident #001 received this medication initially at 2030 hours on an identified date, and then at 0800 hours and 2030 hours daily for the next four days.

During a discussion with Registered Practical Nurse (RPN) #101 and the Resident Assessment Instrument (RAI) Coordinator, they indicated that the letter would have been received by registered staff who would normally place correspondence from the Pharmacist in the Physician's book for them to review. Both of the above noted staff indicated they were not aware of the Pharmacist's alert related to the administration of the above noted drug.

Registered staff did not collaborate with the Pharmacist in the development and implementation of the plan of care when a medication administration alert sent by the Pharmacist was not included in the directions for registered staff related to the safe administration of the above noted drug.

2. The severity of this issue was determined to be a level 3 as there was actual risk to the resident. The scope of the issue was a level 1 as it related to 1 of three residents reviewed. The home had a level 3 compliance history as they had previous non-compliance with the same subsection of the Act that included:
• Voluntary Plan of Correction (VPC) related to s. 6(4)(a) issued April 16, 2019 (2019_556168_0008) (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

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 29th day of January, 2020

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : PHYLLIS HILTZ-BONTJE

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