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 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
Mar 15, 2019	2019_746692_0007	025360-18, 003179-19	Resident Quality Inspection

Licensee/Titulaire de permis

Victoria Village Inc.
76 Ross Street BARRIE ON L4N 1G3

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

Victoria Village Manor
78 Ross Street BARRIE ON L4N 1G3

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

SHANNON RUSSELL (692), JENNIFER BROWN (647), TRACY MUCHMAKER (690)

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): February 19-28, 2019.

The following intakes were inspected upon during this Resident Quality Inspection:
- One log related to Compliance Order (CO) #001 from Inspection report #2018_746692_0008, s. 44 of the Long-Term Care Homes Act (LTCHA), 2007, specific to bed refusals.
- One log was a complaint submitted to the Director, regarding resident care concerns;
- One log related to a critical incident the home submitted to the Director regarding a fall in which the resident was transferred to the hospital;
- One log related to a critical incident the home submitted to the Director, which was related to an alleged resident to resident sexual abuse incident; and
- One log related to a critical incident the home submitted to the Director, in relation to alleged neglect of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing Services (DON), Associate Director of Nursing Services (ADON), Clinical Consultant Pharmacist (CCP), Director of Resident and Family Services (RFSC), Restorative Care Coordinator, Scheduling Coordinator, Nursing Resource Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Community Services Worker (CSW) with Behavioural Support Services (BSS), family members, and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions and resident to resident interactions, reviewed relevant health care records, internal investigation notes, personnel files, as well as numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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
LTCHA, 2007 S.O. 2007, c.8 s. 44. (7)	CO #001	2018_746692_0008	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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Inspector #647 observed Registered Practical Nurse (RPN) #102 administer medications to resident #016 on an identified date at a specified time. The Inspector observed that RPN #102 had dispensed an identified medication from the regular strip package of the scheduled medication that had been located in resident #016's individual unlocked medication box in the medication cart.

Inspector #647 reviewed the home's policy titled, "The Medication Storage", policy #3-4, last reviewed February 2017, which indicated the home refers to narcotic and controlled substances as monitored medications. The Inspector further reviewed the home's policy titled, "Storage of Monitored Medications", policy #6-4, last reviewed February 2017, which indicated that the home was to "store monitored medications, separate from other medications, in a locked compartment of the locked cart in a locked room".

During an interview with the Clinical Consultant Pharmacist (CCP) from the contracted Pharmacy provider for the home, they acknowledged that the identified medication was a classification of medications that were required to be "monitored" as per the Ministry of Health and Long Term Care Act, the Institute for Safe Medication Practices (ISMP), and related best practices. The CCP indicated to Inspector #647 that they had recommended

on several occasions that the home follow the above indicated policy and be compliant with the related legislation, and the home had chosen not to adopt the recommendation. The CCP went on to state to the Inspector, that the home had not had a process in place that would allow for the safe storage of these medications, as they were not being stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

During an interview with Registered Nurse (RN) #115 and RPN #102, they indicated that they do administer the identified medication for physician ordered scheduled or as needed medication to residents. Both registered staff members further indicated to the Inspector that the identified medication was not separated from other scheduled medications in the medication cart.

In an interview with the Director of Nursing (DON), they confirmed that they currently store the identified medication within the routine strip packaging from the pharmacy and not in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, as the legislation required. [s. 129. (1) (b)]

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

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

A Critical Incident (CI) report was submitted to the Director on an identified date, for an incident that occurred on the previous day, related to an allegation of resident to resident abuse.

A further review of the CI report by Inspector #690, indicated that resident #001 was displaying an identified responsive behaviour of a sexual nature toward resident #002, in a private area of the unit. Resident #002 called out to staff for assistance.

A review of resident #001's health records identified a Physician's order dated on an identified date, that indicated that resident #001 was to have a specified intervention for the next two to three days. A further review of the residents health record identified an order by the Nurse Practitioner (NP), the day following the Physician's order, to continue with the specified intervention for seven days and then staff were to reassess based on the response to the treatment.

In an interview with RPN #124, they indicated that they were working on the shift that the above mentioned incident occurred, that they recalled notifying the Physician about the incident and that the Physician ordered the specified intervention for two to three days. RPN #124 further indicated that they also recalled the order from the NP to continue with the specified intervention for seven days. RPN #124 indicated that they did not recall how long resident #001 had the specified intervention in place but recalled that the home was not able to complete the specified intervention for the entire period, as the home did not have enough staff available.

A review of a specific document, provided by the Scheduling Coordinator, indicated that the licensee did not implement the specified intervention for resident #001 for the entire period, as ordered by the Physician and NP.

In an interview with Inspector #690, the Scheduling Coordinator indicated that the home was not able to provide resident #001 with the specified intervention for the entire period, as the home did not have enough staff available.

In an interview with Inspector #690, the DON indicated that they were aware of the order

from the Physician and the NP to provide the specified intervention for resident #001, but that the home was not able to cover the entire period as they did not have enough staff. The DON further indicated that it was the expectation that staff provide care as indicated in the plan of care and that care was not provided as indicated in resident #001's plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months or at any other time when, the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #007 was identified as having an identified injury resulting in being transferred to the hospital from their most recent Resident Assessment Instrument Minimum Data Set (RAI MDS), which resulted from a fall they sustained on an identified date.

Inspector #647 reviewed the residents current care plan, which identified specific fall prevention interventions to be in place for resident #007.

Inspector #647 observed resident #007 on five occasions to review the application of the identified specific interventions. Inspector #647 did not observe a specified intervention to be in place at all times during these observations.

During staff interviews with Personal Support Worker (PSW) #107 and RPN #108, they both informed Inspector #647 that the specified intervention that had been referenced in the plan of care for resident #007, had been in place prior to resident #007's fall on the identified date. PSW #107 further indicated at the time of resident #007's return from hospital, this intervention was no longer required as resident #007's care needs had changed.

In a separate interview with RPN #108, they indicated that all care plans were required to be updated as the resident's status changed or at least on a quarterly basis. Inspector #647 and RPN #108 reviewed the plan of care for resident #007 together, and verified that there had been hand written notes on the care plan when resident #007 returned from hospital, however was not revised to reflect current interventions, as resident #007's care needs had changed after their fall.

Inspector #647 reviewed the home's policy titled "Resident Assessments", policy # VII-D-40.00, last revised July 2017, which stated under procedure "develop and maintain a current plan of care for the resident's care and services". Another document reviewed by

the Inspector titled "Resident Assessment Grid – Nursing Department", further indicated that upon a change in resident status, care plan entries were to be updated.

During an interview with the DON, Inspector #647 reviewed resident #007's current care plan for fall prevention interventions. The DON indicated at this time that care plans were to be kept current with any resident change. The DON confirmed that the specified intervention in the care plan was no longer current for resident #007. [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 care set out in the plan of care is provided to the residents as specified in the plan, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

Sexual abuse is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

A Critical Incident (CI) report was submitted to the Director on an identified date, for an incident that occurred on the previous day, related to an allegation of resident to resident

abuse. Please see WN #2, finding 1 for details.

A review of resident #001's electronic care plan indicated that the resident had a history of exhibiting inappropriate sexual responsive behaviours towards other residents.

A review of resident #001's progress notes by Inspector #690, identified a progress note documented by PSW #122, on an identified date, that indicated that PSW #122 observed resident #001 in a common area displaying an identified responsive behaviour of a sexual nature toward resident #018. Resident #001 was re-directed to another area of the common area, resident #018 was moved to another area of the unit, and that resident #018 "felt better to have been moved".

In a review of resident #018's electronic progress notes, Inspector #690, could not locate any documentation related to the incident that took place on the identified date.

In an interview with Inspector #690, PSW #122 indicated that they had been working on the identified date, and had observed resident #001 in a common area exhibiting an inappropriate responsive behaviour of a sexual nature toward resident #018. PSW #122 indicated that they separated both residents and reported the incident to the RPN #112, who was working on the unit that shift.

In an interview with RPN #112, they indicated that they recalled the incident happening but that they did not document it or report the incident to anyone, including the DON. They further indicated that they did not notify the family members of either resident, the Police, or the Ministry of Health and Long-Term Care. RPN #112 indicated that they did consider this incident to be an allegation of sexual abuse, but they did not know at the time that they were required to report this incident to the DON, but that they were now aware of the requirement.

A review of the home's policy titled "Abuse and Neglect of a Resident-Actual or Suspected #VII-G-10.00" last revised November 2013, indicated that if a staff member becomes aware of potential or actual abuse that they were to notify the CEO or DON immediately. The policy further indicated that CEO or DON would immediately investigate the potential or actual abuse.

In an interview with Inspector #690, the DON indicated that they were not aware of the incident that took place on the identified date, until recently and that RPN #112 should have reported the incident to them so that they could have investigated the incident and

notified the Director, Police and the family members. [s. 20. (1)]

Additional Required Actions:

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

WN #4: 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, procedure, strategy or system, that it was complied with.

Section 114 (2) of O. Reg. 79/10, states that the licensee shall ensure that written policies and protocols were 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.

Inspector #647 reviewed the home's policy titled, "Monitored Medications – Shift Change Monitored Drug Count", policy #6-6, last reviewed February 2017, the policy indicated that monitored medications must be counted daily, at designated shift change in the

home at all times.

Inspector #647 observed RPN #102 administer medications to resident #016 on an identified date at a specified time. The Inspector observed that RPN # 102 had dispensed an identified medication from the regular strip package of scheduled medication.

During an interview with the CCP, they acknowledged that the identified medication was a classification of medications that were required to be "monitored" as per the Ministry of Health and Long Term Care Act, the Institute for Safe Medication Practices (ISMP), and related best practices. The CCP indicated to Inspector #647, that they have recommended to the home on several occasions that the home follow the above indicated policy and be compliant with the related legislation and the home had chosen to not adopt the recommendation. The CCP went on to state to the Inspector, that there was no process in place that would allow for the monitoring of these medications, as the home did not complete a daily count on an ongoing basis or at the designated shift change.

During two separate interviews with Inspector #647, RN #115 and RPN #102, both indicated that they do administer the identified medciation for physician ordered scheduled or as needed medication to residents. These staff members also confirmed at the time of interviews that these "monitored" medications were not documented on the tracking sheet titled “Monitored Medication Record” and were not counted as part of the shift controlled substances count.

In an interview with the DON, they confirmed that the home currently does not monitor the identified medications as they were within the routine individualized strip packaging from pharmacy and were not being counted daily by the registered staff. The DON confirmed that the home should be "monitoring" all controlled substances during the daily shift change controlled substances count. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,

(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the contact information of the Director, or the contact information of a person designated by the Director to receive complaints; 2017, c. 25, Sched. 5, s. 21 (1)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(g.1) a copy of the service accountability agreement as defined in section 21 of the Commitment to the Future of Medicare Act, 2004 entered into between the licensee and a local health integration network;
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(l.1) a written plan for achieving compliance, prepared by the licensee, that the Director has ordered in accordance with clause 153 (1) (b) following a referral under paragraph 4 of subsection 152 (1); 2017, c. 25, Sched. 5, s. 21 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports and orders made by the Director reports from the past two years for the long-term care home were posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements.

During a tour of the home on an identified date, Inspector #690, observed a Ministry of Health (MOH) bulletin board in an identified area of the home and identified inspection reports and order reports from three previous years, but could not locate any inspection reports and order reports from the most recent year.

The DON indicated to Inspector #692, that the Director of Resident and Family Services (DRFS) had removed some documents from the board upon the Inspectors entering the home to ensure that it was the most up to date information.

The next day, the DON and Inspector #690, observed the MOH bulletin board in the identified area of the home, and the DON verified that there were no inspection reports or order reports posted from the most recent year.

In an interview with Inspector #690, the DON indicated that the most recent inspection reports and order reports had not been removed from the board by the DRFS the previous day, that they were checking other documents. The DON further indicated that the most recent inspection reports and order reports had not been posted in the home and that they should have been. [s. 79. (3) (k)]

Issued on this 15th day of March, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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) :	SHANNON RUSSELL (692), JENNIFER BROWN (647), TRACY MUCHMAKER (690)
Inspection No. / No de l'inspection :	2019_746692_0007
Log No. / No de registre :	025360-18, 003179-19
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 15, 2019
Licensee / Titulaire de permis :	Victoria Village Inc. 76 Ross Street, BARRIE, ON, L4N-1G3
LTC Home / Foyer de SLD :	Victoria Village Manor 78 Ross Street, BARRIE, ON, L4N-1G3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Olivia Schmitz

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

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

Order / Ordre :

The licensee must be compliant with r. 129 (1) of the Ontario Regulation 79/10.
Specifically, the licensee shall:
1. Develop and implement a process to ensure that all controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart;
2. Ensure that all registered staff are trained on the process of storing all controlled substances;
3. Maintain a record of the training provided, including dates, times, attendees, trainers and material taught.

Grounds / Motifs :

1. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Inspector #647 observed Registered Practical Nurse (RPN) #102 administer medications to resident #016 on an identified date at a specified time. The

Inspector observed that RPN #102 had dispensed an identified medication from the regular strip package of the scheduled medication that had been located in resident #016's individual unlocked medication box in the medication cart.

Inspector #647 reviewed the home's policy titled, "The Medication Storage", policy #3-4, last reviewed February 2017, which indicated the home refers to narcotic and controlled substances as monitored medications. The Inspector further reviewed the home's policy titled, "Storage of Monitored Medications", policy #6-4, last reviewed February 2017, which indicated that the home was to "store monitored medications, separate from other medications, in a locked compartment of the locked cart in a locked room".

During an interview with the Clinical Consultant Pharmacist (CCP) from the contracted Pharmacy provider for the home, they acknowledged that the identified medication was a classification of medications that were required to be "monitored" as per the Ministry of Health and Long Term Care Act, the Institute for Safe Medication Practices (ISMP), and related best practices. The CCP indicated to Inspector #647 that they had recommended on several occasions that the home follow the above indicated policy and be compliant with the related legislation, and the home had chosen not to adopt the recommendation. The CCP went on to state to the Inspector, that the home had not had a process in place that would allow for the safe storage of these medications, as they were not being stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

During an interview with Registered Nurse (RN) #115 and RPN #102, they indicated that they do administer the identified medication for physician ordered scheduled or as needed medication to residents. Both registered staff members further indicated to the Inspector that the identified medication was not separated from other scheduled medications in the medication cart.

In an interview with the Director of Nursing (DON), they confirmed that they currently store the identified medication within the routine strip packaging from the pharmacy and not in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, as the legislation required

The severity of this issue was determined to be a level one, as there was minimal risk. The scope of the issue was a level three, as it was widespread through the home. The home had a level three compliance history, as they had related non-compliance with this section of the Ontario Regulation 79/10 that included:
-a voluntary plan of correction (VPC) issued December 5, 2017 (#2017_491647_0019).

(647)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 12, 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 15th day of March, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shannon Russell

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