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

Central West Service Area Office
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 02, 2021	2021_781729_0018 (A1)	004261-21, 006921-21, 007640-21, 008820-21, 009124-21, 009806-21, 010802-21	Critical Incident System

Licensee/Titulaire de permis

Holland Christian Homes Inc.
7900 McLaughlin Road South Brampton ON L6Y 5A7

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

Grace Manor
45 Kingknoll Drive Brampton ON L6Y 5P2

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

Amended by KIM BYBERG (729) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Remove PHI from PR

Issued on this 2 nd day of September, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Amended by KIM BYBERG (729) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 13-15, 20-23, 26-30,

Aug 3, 4 and offsite on July 19, 2021.

The following intakes were completed within the critical incident (CI) inspection:

-Log #010802-21, related to a significant change in health status requiring a transfer to the hospital;

-Log #008820-21, related to a significant change in health status requiring a transfer to the hospital;

-Log #009124-21, related to multiple medication incidents;

-Log #007640-21, related to an allegation of staff to resident abuse;

-Log #006921-21, related to an allegation of staff to resident abuse;

-Log #004261-21, related to an allegation of staff to resident abuse;

-Log #009806-21, related to an allegation of resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC),Registered Nurse (RN), Dietary Manager, Nurse Practitioner, Pharmacist, Personal Support Workers (PSW), Agency PSW's, Power Health Care Agency Owner, BSO lead, IPAC lead, Housekeeping, Residents, Visitors and Families.

During this inspection, inspector(s) toured the home, observed residents and the care provided to them, reviewed relevant clinical records, relevant policies, and observed the general maintenance, cleanliness, safety, infection prevention and control practices and condition of the home.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **7 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 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 :

(A1)
1. The licensee has failed to ensure that drugs were administered to twelve residents in accordance with the directions for use specified by the prescriber.

A Critical Incident (CI) was submitted to the Ministry of Long-Term Care (MLTC) related to multiple medication incidents involving twelve residents. The medication incidents involved prescribed medications that were not administered to twelve residents.

The home's policy titled "Holland Christian Homes Policy and Procedure, Medication Administration, Drug Wastage and Drug Destruction", last revised April 27, 2021, policy #PM13, stated that if a medication was refused, or not given for any reason, that information must be appropriately coded onto the residents electronic medical administration record (eMAR) and noted in the progress notes.

A registered staff member stated they found unopened medication pouches that contained medications for multiple residents and all of the medications had been signed for on each resident’s eMAR as administered. The home initiated an investigation and found numerous unopened medication pouches of medications that were not administered to a total of twelve residents, but signed as administered.

When the registered staff member did not administer prescribed medications to twelve residents, it put residents at risk for a change in their health condition which may have required medical intervention.

Sources: Interview with Registered staff members, DOC, and Pharmacist, Review of multiple medication incident reports, review of photos taken in investigation of unopened medication packages, eMAR medication administration records for twelve identified residents, Silver Fox Pharmacy and Drug Destruction: Non-Controlled Substances, Policy #9.1, last revision March 2020 v 2.9, Holland Christian Homes Policy and Procedure, Medication Administration, Drug Wastage and Drug Destruction", last revised April 27, 2021, policy #PM13, Critical incident report, Quality Action Plan for Medication Administration Incidents, Incident Analysis and Re-education/training. [s. 131. (2)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had a fall, their fall prevention interventions were in place as specified in their plan of care.

A report was submitted to the MLTC after a resident was transferred to the hospital with a significant change in their physical health condition following a fall.

One month prior to the resident's fall their plan of care indicated that they have specified fall prevention interventions in place to prevent injury.

A PSW stated that they responded to the resident after they had a fall and they did not have their fall prevention interventions in place. A review of the post fall assessment completed by an RPN at the time of the fall indicated the same.

Sources: Interview with a PSW, RPN, Falls Lead (ADOC), Plan of Care, Post fall assessment, progress notes, point of care documentation, Policy titled “Fall Prevention and Management Program” last revised March 29, 2020. [s. 6. (7)]

2. The licensee has failed to ensure staff documented the care provided to a resident according to their plan of care, specifically, turning and reposition every two hours.

A resident was at end of life and received palliative care. One of the interventions to promote comfort for the resident included turning and repositioning at least every two hours.

The Resident documentation Survey Report-V2 generated from Point of Care (POC) showed staff did not document that the resident was turned and repositioned every two hours for eleven days.

The PSW's caring for the resident said they turned and repositioned the resident every two hours but did not document the care as required.

The licensee has failed to ensure staff documented that the resident was turned and repositioned every two hours. [s. 6. (9) 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 care set out in the plan of care is provided to the resident as specified in the plan and that care is documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was protected from abuse by a Personal Support Worker (PSW).

For the purposes of the definition of “abuse” in subsection 2 (1) of the Long Term Care Act, “emotional abuse” means any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

A CI reported a staff member was abusive to a resident after the resident displayed responsive behaviours towards them.

The PSW said they attempted to provide care to a resident while the resident exhibited responsive behaviours towards the PSW. The PSW said they were abusive towards the resident before exiting the resident's room and as a result the resident had a shocked look on their face. The PSW realized their actions were inappropriate.

The licensee failed to protect a resident from emotional abuse by a PSW and may have caused harm to the resident's psychological well being.

Sources: CI, progress notes, care plan, and interview with a PSW. [s. 19. (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 residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with s. 24 (1) 2. in that a person who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA. Pursuant to s. 152 (2) the licensee is vicariously liable for staff members failing to comply with subsection 24 (1).

A PSW was abusive towards a resident that was displaying responsive behaviours. The PSW did not report their actions to the home's management team until five days later.

Failing to report the incident immediately to the Director resulted in the Director being unable to respond to the incident immediately.

Sources: CI report, the home's investigation, and interview with a PSW [s. 24. (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 when a person who had reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident,
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident,
3. Unlawful conduct that resulted in harm or a risk of harm to a resident,
4. Misuse or misappropriation of a resident's money,
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019. 2007, c. 8, ss. 24 (1), 195 (2); 2019, c. 5, Sched. 3, s. 12 (3), to be implemented voluntarily.

WN #5: 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 has failed to ensure a resident who exhibited altered skin integrity was assessed by a registered staff.

A Resident was observed with multiple areas of skin impairment requiring nursing assessment, intervention and treatment.

The resident's Documentation Survey Report V2 showed the resident was observed with multiple areas of skin impairment and the PSW reported the impairment to the registered staff. There was no evidence that a skin assessment was completed by a registered staff until four days later.

Failure to complete a skin assessment for the resident delayed the follow up to manage the skin impairments and may have caused the resident to experience additional discomfort and further deterioration.

Sources: resident’s progress notes, electronic medical record (eMAR), and Skin assessment, interview with staff. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that an area of skin impairment was reassessed at least weekly by a member of the registered nursing staff.

a) Progress notes stated a resident had an area of skin impairment that was showing signs of infection.

The Skin and Wound Evaluation-V6.0 was completed and described the skin impairment as a new area, with redness and inflammation. There was no evidence to support that a weekly skin assessment was completed over a one month period prior to it being documented as resolved.

The RPN said that weekly skin assessments should be completed for any resident with altered skin integrity until it was resolved.

Sources: resident's progress notes, eMar, and Skin assessment, interview with staff.

b) The licensee failed to ensure a resident's areas of altered skin integrity were reassessed at least weekly by a member of the registered nursing staff.

A resident returned from the hospital after they had a significant change in physical health condition. The initial skin and wound assessments completed, stated the resident had multiple areas of impaired skin integrity.

A review of their skin and wound assessments and progress notes showed that areas of impaired skin integrity were not reassessed weekly after the initial assessment that was completed on their return from the hospital.

The skin and wound care lead, stated that all areas of skin impairment required a weekly skin assessment to be completed. The home completed their skin and wound assessments on Saturdays and the resident should have had an assessment completed weekly but they did not.

The resident may have been at further risk of skin and wound deterioration when staff did not reassess their areas of skin concerns at least weekly.

Sources: Interview with RPN, RN ADOC, Record review of skin and wound evaluation note V6.0 on point click care (PCC), progress notes, home's policy titled "skin and wound care – program overview" last revised February 22, 2021, electronic treatment administration record (eTAR), [s. 50. (2) (b) (iv)]

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 a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff, when a resident exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, and is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between two residents by identifying and implementing interventions.

A CI report stated that a resident alleged a co-resident hit them and caused injury.

A resident had been living in the home for three months and the progress notes identified that on six days within the first two months of them being admitted to the home staff observed the resident exhibiting responsive behaviours.

The resident's plan of care was reviewed and did not include interventions to manage the observed behaviour.

A co-resident's progress notes showed that they had reported to the RPN that someone entered their room and exhibited behaviours towards them. They were able to identify that it was the newly admitted resident.

The registered staff said when a resident had been identified with a responsive behaviour which the resident would be assessed and interventions would be initiated to manage the behaviour. The RPN said this was not done for the newly admitted resident.

Failure to take steps to implement interventions to manage a resident's responsive behaviour may have put other residents at risk of harm. [s. 54. (b)] (606)

Sources: CI report, resident's progress notes, care plans, and interviews with staff. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #7: 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. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that an agency PSW received training on their job responsibilities before they provided care to a resident.

A CI report alleged an agency PSW abused a resident.

The PSW confirmed that they worked in the home, and provided one to one care to a resident. The PSW denied that they were provided orientation on the Home's policies and procedures including resident abuse and neglect, and how to provide care to residents with responsive behaviours. They said they were not provided orientation on the resident's plan of care and did not know the resident they took care of had responsive behaviours.

The PSW's agency and the Home's Administrator acknowledged that the PSW had not received orientation and training prior to being assigned to provide one to one care for a resident.

By not providing training to the agency PSW, prior to them providing care to a resident, the PSW may have been unaware of their responsibilities in relation to s. 76 (2), which put the resident at risk of harm.

Sources: CI, a resident's progress notes and care plan, and interviews with a PSW agency, the owner of Power Healthcare Solutions, and interviews with staff. [s. 76. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
Note: On a day to be named by proclamation of the Lieutenant Governor, paragraph 6 of subsection 76 (2) of the Act is amended by striking out "restraining" and substituting "restraining and confining". (See: 2017, c. 25, Sched. 5, s. 18 (1))
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76 (2), to be implemented voluntarily.

Issued on this 2 nd day of September, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by KIM BYBERG (729) - (A1)
Inspection No. / No de l'inspection :	2021_781729_0018 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	004261-21, 006921-21, 007640-21, 008820-21, 009124-21, 009806-21, 010802-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 02, 2021(A1)
Licensee / Titulaire de permis :	Holland Christian Homes Inc. 7900 McLaughlin Road South, Brampton, ON, L6Y-5A7
LTC Home / Foyer de SLD :	Grace Manor 45 Kingknoll Drive, Brampton, ON, L6Y-5P2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jessica Radon

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 :

(A1)
The licensee must be compliant with O. Reg. 79/10, s. 131 (2).

Specifically, the licensee must:

A) Ensure that drugs are administered to residents in accordance with the directions for use by the specified prescriber.

B) Ensure that any drug that is refused by residents is disposed of and documented in their electronic medical record in accordance with the home's policy titled "Holland Christian Homes Policy and Procedure, Medication Administration, Drug Wastage and Drug Destruction" policy #PM13

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that drugs were administered to twelve residents in accordance with the directions for use specified by the prescriber.

A Critical Incident (CI) was submitted to the Ministry of Long-Term Care (MLTC) related to multiple medication incidents involving twelve residents. The medication incidents involved prescribed medications that were not administered to twelve residents.

The home's policy titled "Holland Christian Homes Policy and Procedure, Medication Administration, Drug Wastage and Drug Destruction", last revised April 27, 2021,

policy #PM13, stated that if a medication was refused, or not given for any reason, that information must be appropriately coded onto the residents electronic medical administration record (eMAR) and noted in the progress notes.

A registered staff member stated they found unopened medication pouches that contained medications for multiple residents and all of the medications had been signed for on each resident's eMAR as administered. The home initiated an investigation and found numerous unopened medication pouches of medications that were not administered to a total of twelve residents, but signed as administered.

When the registered staff member did not administer prescribed medications to twelve residents, it put residents at risk for a change in their health condition which may have required medical intervention.

Sources: Interview with Registered staff members, DOC, and Pharmacist, review of multiple medication incident reports, review of photos taken in investigation of unopened medication packages, eMAR medication administration records for twelve identified residents, Silver Fox Pharmacy and Drug Destruction: Non-Controlled Substances, Policy #9.1, last revision March 2020 v 2.9, Holland Christian Homes Policy and Procedure, Medication Administration, Drug Wastage and Drug Destruction", last revised April 27, 2021, policy #PM13, Critical incident report, Quality Action Plan for Medication Administration Incidents, Incident Analysis and Re-education/training. [s. 131. (2)]

Severity: There was a potential risk of harm to twelve residents when their medication was not given in accordance with the directions for use by the prescriber.

Scope: The scope of this non-compliance was widespread as medications were not administered, but documented as administered to twelve out of twelve residents reviewed during this inspection

Compliance History: CO#005 was issued on February 27, 2020 (inspection #2020_793743_0003) with a compliance due date of July 31, 2020. This order was complied. In the past 36 months, 8 other compliance orders have been issued.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

(729)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Aug 24, 2021

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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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 2 nd day of September, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by KIM BYBERG (729) - (A1)

Order(s) of the Inspector

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Service Area Office / Bureau régional de services : Central West Service Area Office