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

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

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

Public Copy/Copie du 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
Dec 10, 2021	2021_833763_0022	007820-21, 009662-21, 014994-21, 015702-21	Complaint

Licensee/Titulaire de permis

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

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

Woodbridge Vista Care Community
5400 Steeles Avenue West Woodbridge ON L4L 9S1

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

IANA MOLOGUINA (763), DEREGE GEDA (645), IVY LAM (646)

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): November 4, 5, 8, 9, 12, 16, 17, 18, and 19, 2021.

The following intakes were completed during this Complaint Inspection:

- Log #014994-21 was related to admission protocol, falls and change in condition, and
- Log #009662-21 was related to medication management.

The following Critical Incident System (CIS) intakes related to the same issues (a fall and medication incident) were completed during this Complaint inspection:

- Log #015702-21, CIS #2945-000054-21, and
- Log #007820-21, CIS #2945-000034-21.

PLEASE NOTE: A Compliance Order (CO) related to O. Reg. 79/10, s. 114. (3) (a), identified in a concurrent inspection #2021_833763_0023 (Log #016064-20, CIS #2945-000027-20) was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and residents' family members.

During the course of this inspection, the inspectors reviewed residents' clinical records and conducted observations, including staff-resident interactions, meal observations and resident care provisions.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Medication
Safe and Secure Home

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

2 WN(s)
0 VPC(s)
2 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents when they did not maintain functioning oxygen concentrators in the home.

The Ministry of Long-Term Care (MLTC) received a complaint from a resident family indicating that the home failed to adequately respond to the resident's change in condition as staff were unable to locate functioning oxygen concentrators during a medical emergency.

A Critical Incident System (CIS) report for the same concerns was submitted by the home to the MLTC. The staff called for an ambulance when the resident's condition declined. While awaiting the ambulance, the resident had a change in condition. Emergency interventions were initiated but the resident expired once the paramedics arrived.

Staff interviews and record reviews confirmed that at the time of the medical emergency, the emergency oxygen concentrator at the nursing station was missing a part. Staff brought several replacement concentrators from other units and were able to administer oxygen on the third attempt. The home's investigation of the incident revealed that routine checks of oxygen concentrators, as per the home's practices, were not being conducted to monitor the functionality of the available concentrators. The DOC also indicated that the home's oxygen contractor was not being contacted for routine maintenance when emergency concentrators were used, as they required maintenance after each use. The home restarted daily checks of oxygen concentrators on each unit since the investigation of the incident and provided education to staff on procedures to follow for oxygen concentrator maintenance.

Sources: resident clinical records (PointClickCare profile, progress notes); CIS report #2945-000054-21; oxygen concentrator monitoring logs (October, 2021); VitalAire Home Healthcare service logs and education material; family interviews; staff interviews (PSW #126 and DOC #104). [s. 5.]

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 O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff implemented the home’s medication reconciliation policy.

The home's medication reconciliation policy indicated that medication reconciliation during a resident admission was a multidisciplinary process that ensured accuracy and continuity of medication orders and reduced potential adverse events or harm. The policy directed staff members to obtain accurate information regarding medication use from a variety of sources including a discussion with the resident, family or their primary caregiver. Emphasis was given to identifying and reviewing high alert medications and antipsychotics. For residents coming from the community, staff were to review all medications and seek clarifications on use with the resident and knowledgeable family member to determine an accurate medication list. The nurse and/or physician was to communicate changes from the medical history to the current orders to the resident or family member, and document the consent conversation in the clinical progress notes.

The MLTC received a complaint from a resident family indicating that the home prescribed a medication upon admission when the resident never took that medication prior to their admission. The family indicated that the medication resulted in them becoming lethargic and causing a fall with injury a few days after their admission. A CIS report for the same concerns was submitted by the home to the MLTC, indicating that the resident passed away a few days after the fall occurred.

Home records indicated that the resident's Community Care Access Centre (CCAC)

admission assessment listed several medications, including the medication specified above to be taken daily. A pharmacy list from the community listed the same medications but did not include the identified medication. The resident was prescribed the identified medication in the home, though the dosage was reduced following their fall.

The nurse who completed admission paperwork for the resident confirmed they were aware of the discrepancy in the medication lists in the CCAC assessment files and the community pharmacy records, but that they did not review the discrepancies with the family in detail on the day of admission. They assumed the CCAC assessment included the most up-to-date medication list and recommended the doctor order the antipsychotic.

Clinical records and staff interviews indicated that the day after their admission, the resident became more lethargic, sleeping throughout the day. The family was concerned and asked the doctor to review their medication regimen. The resident's oral intakes declined, they continued to be more sleepy than usual, and had a fall four days later. The doctor lowered the medication dosage two days later.

The DOC confirmed that the admitting nurse should have thoroughly reviewed the medication list with the resident's family on admission as indicated in the home's medication reconciliation policy.

Sources: resident clinical records (PointClickCare profile, progress notes, assessments, eMAR, physical chart); CIS #2945-000054-21; “Medication Reconciliation” policy 7-2 (revised February, 2017); family interviews; staff interviews (RN #122 and DOC #104).
[s. 114. (3) (a)]

2. The licensee has failed to ensure that staff implemented the home’s safe medication administration, transcription and dispensing protocol and policy.

The home's policy, “Medication Management: Physician-Nurse Practitioner Orders Guidelines, #VIII-E-10.20(a)” and “Diabetes Management, VIII-C-10.60”, directed staff members to do the following procedures when a new order was received/obtained from a physician/Nurse Practitioner :

- write the name of the medication, dosage and route in the physician order section and eMAR,
- include resident’s name, date and time of order

- purpose of therapeutic outcome expected from the medication and,
- duration of therapy, prescriber's name, designation and signature.

The registered staff who received the order was responsible to follow up when the medication order was unclear, incomplete, inappropriate, or misunderstood. The second nurse who was witnessing the medication order was responsible to make sure the medication order was accurate and transcribed correctly.

A CIS report was submitted to the MLTC regarding a medication incident. The report indicated RPN #106 administered a much higher dose of medication than required when the resident's condition changed.

RPN #106 obtained an order for immediate administration from the physician when the resident's condition declined. The home's investigation records and the eMAR indicated that the physician order was not written in the order section of the chart, nor transcribed in the eMAR; the dosage administered was not signed and the order was not co-signed by a second nurse.

DOC #104 confirmed that the RPN did not write or transcribe the medication order in the paper chart or the eMAR. The medication order was not co-signed and the eMAR was not signed after administration. They indicated that it was the expectation of the home that registered staff transcribe orders and verify an order by a second nurse to prevent medication errors. They indicated that the home had a process and policy in place to manage medication orders and confirmed that RPN #106 did not implement the program.

Failure to transcribe medication orders and implement the home's safe medication administration policy, would pose risk to residents and affect their well-being.

Sources: resident's eMAR, investigation records, progress notes; "Medication Management: Physician-Nurse Practitioner Orders Guidelines, #VIIIE-10.20(a)" policy (revised June, 2020); "Diabetes Management, VIII-C-10.60" policy (revised June, 2020); and interview with the DOC. [645] [s. 114. (3) (a)]

3. The licensee has failed to ensure that staff implemented the home's safe narcotic medication administration, dispensing and controlled substance inventory count policy.

The home's policy, "Medication Management: Monitored Medication, Controlled Substance Inventory Count, and Narcotic Administration, #VIII-E-10.40", directed

registered staff members to do the following:

- document the administration of monitored/narcotic medications on the resident’s eMAR,
- sign on the “Individual Monitoring Medication record” each time a dose was administered. Include date, time, amount given/wasted and quantity remaining,
- the individual narcotic monitoring record was to be audited regularly for accuracy,
- conduct a controlled substance and narcotic count between each shift change. Verification is done with the nurse coming on duty and the nurse going off duty,
- sign the controlled substance/narcotic count record sheet after count was completed. Both the oncoming and off going nurses were responsible to sign and verify the accuracy of the count and
- report discrepancies to the DOC.

A CIS report was submitted to the MLTC regarding missing narcotic medication. The report indicated that a resident's opioid medication was missing.

The home’s investigation record indicated that RPN #130 observed RPN #108 conducting the end of shift narcotic count by themselves, and when asked, RPN #108 indicated that they were doing the count alone because they were missing one opioid medication tablet. The notes indicated that RPN #108 tampered the narcotic record sheet count in an attempt to change the count numbers. RPN #130 recounted the narcotics, verified the narcotic discrepancy for the missing medication and notified DOC #130. During the home’s investigation, RPN #108 indicated that they dispensed the opioid medication earlier in their shift prior to the administration time and stored it elsewhere in the medication cart but later were unable to locate it. Review of the records also indicated that RPN #108 did not sign on the resident’s eMAR, and the individual narcotic dispensing sheet. The notes indicated that RPN #108 was counseled to only dispense medication at the time of administration, and immediately sign on the eMAR and the narcotic sheet.

Interview with the current DOC #104 indicated that it was the expectation of the home that registered staff document the administration of monitored/narcotic medications on the resident’s eMAR, sign on the individual narcotic monitoring sheet each time a dose is administered, and conduct controlled substance/narcotic count between each shift change with the oncoming nurse. They confirmed that RPN #108 did not implement the home’s controlled substance inventory count, and narcotic administration policy and procedures.

Sources: resident's eMAR and progress notes; CIS report #2945-000027-20; the home's investigation records; “Medication Management: Monitored Medication, Controlled Substance Inventory Count, and Narcotic Administration, #VIII-E-10.40" (revised May, 2019); and interview with the DOC. [645] [s. 114. (3) (a)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

Issued on this 6th day of January, 2022

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

Original report signed by the inspector.

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	IANA MOLOGUINA (763), DEREGE GEDA (645), IVY LAM (646)
Inspection No. / No de l'inspection :	2021_833763_0022
Log No. / No de registre :	007820-21, 009662-21, 014994-21, 015702-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Dec 10, 2021
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Woodbridge Vista Care Community 5400 Steeles Avenue West, Woodbridge, ON, L4L-9S1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lorraine Gibson

---

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

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

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must comply with s. 5 of LTCHA 2007, c. 8.

Specifically, the licensee must:

- Work with the service provider to ensure all oxygen concentrators in the home are in good working order and available to staff at all times.
- Perform audits of oxygen concentrators in the home according to current best practice guidelines; and if there are none, according to the best practice guidelines agreed upon by the home/licensee and the oxygen provider.

Grounds / Motifs :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents when they did not maintain functioning oxygen concentrators in the home.

The Ministry of Long-Term Care (MLTC) received a complaint from a resident family indicating that the home failed to adequately respond to the resident's change in condition as staff were unable to locate functioning oxygen concentrators during a medical emergency.

A Critical Incident System (CIS) report for the same concerns was submitted by the home to the MLTC. The staff called for an ambulance when the resident's condition declined. While awaiting the ambulance, the resident had a change in condition. Emergency interventions were initiated but the resident expired once the paramedics arrived.

Staff interviews and record reviews confirmed that at the time of the medical

emergency, the emergency oxygen concentrator at the nursing station was missing a part. Staff brought several replacement concentrators from other units and were able to administer oxygen on the third attempt. The home's investigation of the incident revealed that routine checks of oxygen concentrators, as per the home's practices, were not being conducted to monitor the functionality of the available concentrators. The DOC also indicated that the home's oxygen contractor was not being contacted for routine maintenance when emergency concentrators were used, as they required maintenance after each use. The home restarted daily checks of oxygen concentrators on each unit since the investigation of the incident and provided education to staff on procedures to follow for oxygen concentrator maintenance.

Sources: resident clinical records (PointClickCare profile, progress notes); CIS report #2945-000054-21; oxygen concentrator monitoring logs (October, 2021); VitalAire Home Healthcare service logs and education material; family interviews; staff interviews (PSW #126 and DOC #104).

An order was made by taking the following factors into account:

Severity: There was actual risk of harm because the resident did not receive immediate oxygen administration during a medical emergency.

Scope: The scope of this non-compliance was widespread because the licensee did not maintain functioning oxygen concentrators throughout the home.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 5 and two written notifications (WNs) and two compliance orders (CO) were issued to the home. (763)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 21, 2021

Order # / No d'ordre : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Order / Ordre :

The licensee must comply with s. 114 (3) of O. Reg. 79/10.

Specifically, the licensee must:

- Ensure staff implement all of the home's current medication management related policies relating to medication reconciliation, administration, transcription, dispensing, and controlled substance inventory counting.
- Educate all registered nursing staff on all of the above policies and procedures, keeping a record of training provided, including the content, staff involved, and dates of training. The training dates must be after September 30, 2021.
- Keep a record of all medication incidents and any actions taken to address noted concerns, making records available for review by the inspector.

Grounds / Motifs :

1. The licensee has failed to ensure that staff implemented the home's medication reconciliation policy.

The home's medication reconciliation policy indicated that medication reconciliation during a resident admission was a multidisciplinary process that ensured accuracy and continuity of medication orders and reduced potential adverse events or harm. The policy directed staff members to obtain accurate information regarding medication use from a variety of sources including a

discussion with the resident, family or their primary caregiver. Emphasis was given to identifying and reviewing high alert medications and antipsychotics. For residents coming from the community, staff were to review all medications and seek clarifications on use with the resident and knowledgeable family member to determine an accurate medication list. The nurse and/or physician was to communicate changes from the medical history to the current orders to the resident or family member, and document the consent conversation in the clinical progress notes.

The MLTC received a complaint from a resident family indicating that the home prescribed a medication upon admission when the resident never took that medication prior to their admission. The family indicated that the medication resulted in them becoming lethargic and causing a fall with injury a few days after their admission. A CIS report for the same concerns was submitted by the home to the MLTC, indicating that the resident passed away a few days after the fall occurred.

Home records indicated that the resident's Community Care Access Centre (CCAC) admission assessment listed several medications, including the medication specified above to be taken daily. A pharmacy list from the community listed the same medications but did not include the identified medication. The resident was prescribed the identified medication in the home, though the dosage was reduced following their fall.

The nurse who completed admission paperwork for the resident confirmed they were aware of the discrepancy in the medication lists in the CCAC assessment files and the community pharmacy records, but that they did not review the discrepancies with the family in detail on the day of admission. They assumed the CCAC assessment included the most up-to-date medication list and recommended the doctor order the antipsychotic.

Clinical records and staff interviews indicated that the day after their admission, the resident became more lethargic, sleeping throughout the day. The family was concerned and asked the doctor to review their medication regimen. The resident's oral intakes declined, they continued to be more sleepy than usual, and had a fall four days later. The doctor lowered the medication dosage two days later.

The DOC confirmed that the admitting nurse should have thoroughly reviewed the medication list with the resident's family on admission as indicated in the home's medication reconciliation policy.

Sources: resident clinical records (PointClickCare profile, progress notes, assessments, eMAR, physical chart); CIS #2945-000054-21; "Medication Reconciliation" policy 7-2 (revised February, 2017); family interviews; staff interviews (RN #122 and DOC #104).

2. The licensee has failed to ensure that staff implemented the home's safe medication administration, transcription and dispensing protocol and policy.

The home's policy, "Medication Management: Physician-Nurse Practitioner Orders Guidelines, #VIII-E-10.20(a)" and "Diabetes Management, VIII-C-10.60", directed staff members to do the following procedures when a new order was received/obtained from a physician/Nurse Practitioner :

- write the name of the medication, dosage and route in the physician order section and eMAR,
- include resident's name, date and time of order
- purpose of therapeutic outcome expected from the medication and,
- duration of therapy, prescriber's name, designation and signature.

The registered staff who received the order was responsible to follow up when the medication order was unclear, incomplete, inappropriate, or misunderstood. The second nurse who was witnessing the medication order was responsible to make sure the medication order was accurate and transcribed correctly.

A CIS report was submitted to the MLTC regarding a medication incident. The report indicated RPN #106 administered a much higher dose of medication than required when the resident's condition changed.

RPN #106 obtained an order for immediate administration from the physician when the resident's condition declined. The home's investigation records and the eMAR indicated that the physician order was not written in the order section of the chart, nor transcribed in the eMAR; the dosage administered was not

signed and the order was not co-signed by a second nurse.

DOC #104 confirmed that the RPN did not write or transcribe the medication order in the paper chart or the eMAR. The medication order was not co-signed and the eMAR was not signed after administration. They indicated that it was the expectation of the home that registered staff transcribe orders and verify an order by a second nurse to prevent medication errors. They indicated that the home had a process and policy in place to manage medication orders and confirmed that RPN #106 did not implement the program.

Failure to transcribe medication orders and implement the home’s safe medication administration policy, would pose risk to residents and affect their well-being.

Sources: resident's eMAR, investigation records, progress notes; "Medication Management: Physician-Nurse Practitioner Orders Guidelines, #VIIIE-10.20(a)" policy (revised June, 2020); "Diabetes Management, VIII-C-10.60" policy (revised June, 2020); and interview with the DOC. [645]

3. The licensee has failed to ensure that staff implemented the home’s safe narcotic medication administration, dispensing and controlled substance inventory count policy.

The home's policy, “Medication Management: Monitored Medication, Controlled Substance Inventory Count, and Narcotic Administration, #VIII-E-10.40”, directed registered staff members to do the following:

- document the administration of monitored/narcotic medications on the resident’s eMAR,
- sign on the “Individual Monitoring Medication record” each time a dose was administered. Include date, time, amount given/wasted and quantity remaining,
- the individual narcotic monitoring record was to be audited regularly for accuracy,
- conduct a controlled substance and narcotic count between each shift change. Verification is done with the nurse coming on duty and the nurse going off duty,
- sign the controlled substance/narcotic count record sheet after count was completed. Both the oncoming and off going nurses were responsible to sign

and verify the accuracy of the count and
- report discrepancies to the DOC.

A CIS report was submitted to the MLTC regarding missing narcotic medication. The report indicated that a resident's opioid medication was missing.

The home's investigation record indicated that RPN #130 observed RPN #108 conducting the end of shift narcotic count by themselves, and when asked, RPN #108 indicated that they were doing the count alone because they were missing one opioid medication tablet. The notes indicated that RPN #108 tampered the narcotic record sheet count in an attempt to change the count numbers. RPN #130 recounted the narcotics, verified the narcotic discrepancy for the missing medication and notified DOC #130. During the home's investigation, RPN #108 indicated that they dispensed the opioid medication earlier in their shift prior to the administration time and stored it elsewhere in the medication cart but later were unable to locate it. Review of the records also indicated that RPN #108 did not sign on the resident's eMAR, and the individual narcotic dispensing sheet. The notes indicated that RPN #108 was counseled to only dispense medication at the time of administration, and immediately sign on the eMAR and the narcotic sheet.

Interview with the current DOC #104 indicated that it was the expectation of the home that registered staff document the administration of monitored/narcotic medications on the resident's eMAR, sign on the individual narcotic monitoring sheet each time a dose is administered, and conduct controlled substance/narcotic count between each shift change with the oncoming nurse. They confirmed that RPN #108 did not implement the home's controlled substance inventory count, and narcotic administration policy and procedures.

Sources: resident's eMAR and progress notes; CIS report #2945-000027-20; the home's investigation records; "Medication Management: Monitored Medication, Controlled Substance Inventory Count, and Narcotic Administration, #VIII-E-10.40" (revised May, 2019); and interview with the DOC. [645]

An order was made by taking the following factors into account:

Severity: There was actual harm because the resident experienced adverse health events due to the staff not following the home's medication reconciliation policy.

Scope: The scope of this non-compliance was widespread because staff didn't follow the home's medication policies in all three incidents reviewed.

Compliance History: 77 written notifications (WN), 35 voluntary plans of correction (VPC), 19 compliance orders (CO), and four director referrals (DR) were issued to the home related to different sub-sections of the legislation in the past 36 months. (763)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 10, 2022

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 10th day of December, 2021

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Iana Mologuina

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