Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Amended Public Report Cover Sheet (A2)

Amended Report Issue Date: January 25, 2024	
Original Report Issue Date: January 2, 2024	
Inspection Number: 2023-1616-0005 (A2)	
Inspection Type: Complaint Critical Incident	
Licensee: The Corporation of the County of Renfrew	
Long Term Care Home and City: Miramichi Lodge, Pembroke	
Amended By Maryse Lapensee (000727)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to:
Remove Non-compliance under O. Reg 246/22, s. 102 (2) (b) related to Infection Prevention and Control.

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Amended Public Report (A2)

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Inspection Number: 2023-1616-0005 (A2)	
Inspection Type: Complaint Critical Incident	
Licensee: The Corporation of the County of Renfrew	
Long Term Care Home and City: Miramichi Lodge, Pembroke	
Lead Inspector Maryse Lapensee (000727)	**Additional Inspector(s)** Severn Brown (740785) Shevon Thompson (000731)
Amended By Maryse Lapensee (000727)	**Inspector who Amended Digital Signature**

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 28, 29, 30, 2023 and December 1, 5, 6, 2023

The following intakes were inspected during this complaint inspection:

- Intake: #00099737 -related to palliative care, resident care and home safety

The following intakes were inspected during this Critical Incident (CI) inspection:

- Intake: #00095860 - related to alleged neglect of resident by staff
- Intake: #00096762 - related to resident to resident physical abuse
- Intake: #00099146 - related to Improper/Incompetent treatment of resident by staff
- Intake: #00100524 - related to a written complaint about food temperatures
- Intake: #00100785 - related to RSV outbreak
- Intake: #00096753 and Intake: #00101921 - related to fall with injury resulting in a significant change in condition

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

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AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to,
iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure the respect and promotion of the residents' right to have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act.

Rationale and Summary
On November 30, 2023, inspector #000731 observed that a computer on a medication cart, on a unit of the first floor was open to a page on the electronic Medication Administration Record (e-MAR) with a listing of multiple residents including pictures and names of the residents and easy access to their health information. A Registered Practical Nurse confirmed they were on duty and

acknowledged that the e-MAR was left open.

In an interview with a RPN, they confirmed that when the medication cart is outside the medication room and a computer is on it but the computer is not in use, the RPN is expected to lock the computer screen as there is vital, resident specific information on the screen that needs to be secure. The Acting Director of Care confirmed that when the medication cart with the computer was outside the medication room and was not in use the RPN was expected to set the e-MAR on the computer to the privacy screen and lock it so that residents' information was not accessible for viewing.

Not locking the e-MAR screen places residents at risk for the unauthorized access to their personal health information.

Sources: Inspector observation on first floor unit, Interview with registered staff member and Acting DOC. [000731]

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (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.

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The licensee has failed to ensure that an incident of alleged neglect was reported to the Director.

Rationale and Summary
Resident Care Coordinator (RCC) stated that a staff member emailed them on a specific date communicating multiple concerns regarding resident care by a Registered Practical Nurse (RPN) to three residents from the previous night shift. The Registered Nurse (RN) stated in their interview with Inspector #740785 that they were informed of these concerns by a Personal Support Worker (PSW) after their shift had been completed the morning of the specific date and directed the PSW to communicate the concerns to the RCC. The RCC stated they questioned the RPN about the head injury routine assessments required for a specific resident on a specific shift on a date and found that the RPN did not complete the assessments on the resident as required.

Review of the Critical Incident (CI) and the CI database, by the inspector, showed no report of the specific incident of neglect related to a resident on or after the specified date.

By not ensuring that an incident of alleged improper care was reported to the Director immediately, a resident was put at risk of not receiving adequate regulatory resources to ensure their safety and quality of life.

Sources: Interview with RCC; Employer Investigation Report for an incident in October 2023 conducted by RCC; CI and CI database on ltchomes.net
[740785]

WRITTEN NOTIFICATION: Doors in a home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when unsupervised by staff.

Rationale and Summary
During the course of the inspection, multiple clean and soiled utility rooms were observed to be open and unlocked by inspector #740785. Two of the observed rooms had signs stating "keep room door closed and locked." The Acting DOC stated that clean and soiled utility rooms must be closed and locked when not in use.

By not ensuring that clean and soiled utility rooms were closed and locked when unsupervised, residents were placed at risk for injury.

Sources: Observations of multiple clean and soiled utility rooms. Interview with Acting DOC
[740785]

WRITTEN NOTIFICATION: Dining and snack service

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure that the food served to a resident was at a temperature that was both safe and palatable to the resident.

Rationale and Summary
A review of the home's Temperature Record Sheet from a specific date, indicated that the stew served to a resident was at 186 degrees Fahrenheit. An e-mail sent by the Food Service Supervisor to the Acting Director of Care indicated that the temperature of the stew for a resident's meal was at 186 degrees Fahrenheit. The acceptable temperature range identified in the e-mail was 140 to 170 degrees Fahrenheit. A Dietary Communication Book note, indicated that on the previous day a resident had received food above the acceptable temperature range for serving. The acceptable temperature range indicated for serving hot foods was 140 to 170 degrees Fahrenheit (60 to 75 degrees Celsius) as indicated in the note.

In an interview with a Registered Dietitian (RD), they stated that on a specified date, the Food Service Worker had informed them that the hot food temperatures were between 180 to 190 degrees Fahrenheit. The RD confirmed that hot food temperatures should be between 140 to 170 degrees Fahrenheit before serving. The

Food Service Supervisor (FSS) confirmed that the specific temperature of the stew served to a resident was in the email provided to the inspector. The temperature of the stew noted in the e-mail was 186 degrees Fahrenheit. The FSS affirmed that hot foods should be served between 140 and 170 degrees which was indicated on the temperature records.

Failure to ensure foods are served at a temperature that is both safe and palatable to the residents places the resident at risk for injury and for not having a pleasurable dining experience.

Sources: Temperature Record Sheet dated a specific date, e- mail by FSS to ADOC , Dietary Communication Book note, interview with RD, and Interview with FSS. [000731]

WRITTEN NOTIFICATION: Licensees who fail to report investigations under the Act

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 112 (3)
Licensees who report investigations under s. 27 (2) of Act
s. 112 (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director.

#1
The licensee has failed to ensure that a preliminary report related to an incident of alleged neglect was submitted 10 days after being reported to the Director. Further,

the licensee has failed to ensure that a final report related to the reported incident was submitted within the time period, 21 days, specified by the Director.

Rationale and Summary
A Critical Incident (CI) report was submitted by the home to the Director related to an incident of alleged abuse or neglect in the home. Upon review of the CI and its amendments on the CI database, no preliminary report was submitted to the Director related to the home's investigation into the incident within 10 days of the home becoming aware of the allegations. Upon review of the CI report submitted to the Director and the CI database, the final report related to the home's investigation was submitted to the Director after the time period of 21 days to make a final report on an investigation into abuse or neglect, as specified in the Minister's Directive for Reporting Requirements for Long-Term Care Homes. The RCC stated that a preliminary report to the incident was not submitted to the Director within 10 days of it occurring and the final report was being submitted on the day of the RCC's interview.

By not ensuring that the specified time periods for preliminary and final reports of investigations for reporting to the Director were complied with, residents are put at risk of not having access to all regulatory resources to ensure their safety and quality of life.

Sources: CI; CI database on ltchomes.net; Interview with the RCC.
[740785]

#2
The licensee has failed to ensure that a preliminary report related to an incident of alleged neglect was submitted 10 days after being reported to the Director. Further, the licensee has failed to ensure that a final report related to the reported incident

was submitted within the time period, 21 days, specified by the Director.

Rationale and Summary
In August 2023, the RCC submitted a report to the Director related to alleged incidents of neglect in the home. Upon review of Critical Incident (CI) report submitted to the Director, and the CI database, no preliminary report on the home's investigation was submitted to the Director related to the incident within 10 days of the home becoming aware of the allegations. Upon review of the CI report submitted to the Director and the CI database, the final report related to the home's investigation was not submitted to the Director within the time period of 21 days as specified in the Minister's Directive for Reporting Requirements for Long-Term Care Homes. The RCC stated that a preliminary report to the incident was not submitted to the Director within 10 days of it occurring.

By not ensuring that the specified time periods for preliminary and final reports of investigations for reporting to the Director were complied with, residents are put at risk of not having access to all regulatory resources to ensure their safety and quality of life.

Sources: CI; CI database on ltchomes.net; Interview with RCC.
[740785]

WRITTEN NOTIFICATION: Security of drug supply

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 1.
Security of drug supply
s. 139 1. All areas where drugs are stored shall be kept locked at all times, when not in use.

The licensee has failed to ensure that all areas where drugs are stored are locked at all times, when not in use.

Rationale and Summary
During the inspection, the medication storage room was observed to be open and unsupervised on a specific unit. On another day, the medication storage room was observed to be open and unsupervised on a different unit. Registered Practical Nurse (RPN) stated that the medication room must be locked when not being used. Acting DOC stated that medication storage rooms must be closed and locked at all times when not in use.

By not ensuring that the medication storage rooms were closed and locked when not in use, residents were put at risk of accessing drugs that could potentially harm them.

Sources: Observations of medication rooms on two units; Interviews with RPN and Acting DOC
[740785]

COMPLIANCE ORDER CO #001 Policy to promote zero tolerance

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in

section 24, 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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

A) Provide education to two specified staff members on the home's policy regarding zero tolerance of abuse or neglect. Specifically the home shall ensure that the specified staff members are provided education on their reporting expectations specific to their role in the home.

B) Conduct audits for a period of four weeks on all incidents (if any) of alleged abuse or neglect to ensure that the reporting requirements as specified in the home's policy for zero tolerance of abuse or neglect is complied with.

C) Take corrective actions if any deviations from the home's policy for the prevention of abuse or neglect are determined to ensure compliance.

D) Keep a written record for the requirements specified in sections (A), (B), and (C) of this order.

Grounds
#1
The licensee has failed to ensure that their policy to promote zero-tolerance of resident abuse or neglect was complied with. Specifically, the licensee failed to ensure that a Registered Nurse (RN) immediately reported alleged improper care to

three residents by a registered staff member on a specific date to the manager on-call.

Rationale and Summary
On a specific date, two Personal Support Workers (PSW) reported to the charge RN allegations of improper care of three residents by a Registered Practical Nurse (RPN). The RN stated when they received the allegations of improper care and neglect by the RPN, they emailed the RCC but did not phone the manager on-call. The RCC stated that the RN should have called the manager on-call. Acting DOC stated that during non-business hours the RN is to call the manager on-call to ensure that the Ministry of Long-Term Care's After Hours pager is contacted to ensure that they are in compliance with their reporting requirements. Policy G-006: Prevention of Resident Abuse or Neglect states that when abuse or inappropriate care is suspected an immediate report to MLTC pager during non-business hours must be made.

By not ensuring the RN informed the manager on-call of the allegations of improper care to three residents by the other registered staff member, the residents were placed at risk of not having adequate managerial and regulatory oversight in the response to the allegations.

Sources: The home's investigation notes and interviews with staff members, registered staff member, RCC and Acting DOC; Policy G-006: Prevention of Resident Abuse and Neglect, last reviewed February 1, 2023.
[740785]

#2
The licensee has failed to ensure that their policy to promote zero-tolerance of resident abuse or neglect was complied with. Specifically, the licensee failed to

ensure that a staff member immediately reported alleged improper care of three residents as well as an allegation of verbal abuse towards another resident by a registered staff on a specific date to their superior.

Rationale and Summary
On a specific date a staff member became aware of allegations of improper care of three residents by a RPN. Furthermore, the staff member did not immediately report an incident of alleged verbal abuse by the RPN towards a resident, to their supervisor. In their interview conducted by RCC on a specific date, during the home's investigation into the incident, the PSW stated that the RPN told them that they did not provide pain medication to a resident as requested. The RPN made a derogatory comment in front of the PSW and other residents regarding another resident. The staff member further stated they did not inform their supervisor of these allegations until after their shift had been completed. The charge RN stated that the staff member did not report allegations of improper care to three residents and an allegation of verbal abuse to a resident by the RPN, until after their shift. The Acting DOC stated that if any staff become aware of any allegations of abuse or neglect they must report it to their supervisor, who is the RN during non-business hours, immediately. Policy G-006: Prevention of Resident Abuse and Neglect states that anyone who witnesses any form of abuse/neglect/inappropriate care or is aware of alleged or suspected abuse/neglect/inappropriate care is responsible for reporting it to their superior immediately.

By not ensuring that allegations of improper care to three residents and an allegation of verbal abuse to another resident were reported immediately by the staff member to the charge RN, these residents were placed at risk of not being provided immediate interventions to ensure their safety and well being.

Sources: The home's investigation notes and interview with staff member,

registered staff member, RCC, and Acting DOC; Policy G-006: Prevention of Resident Abuse and Neglect last reviewed February 1, 2023.
[740785]

This order must be complied with by February 9, 2024

COMPLIANCE ORDER CO #002 Reporting certain matters to Director

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (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:
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.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

A) Provide education to four staff members on mandatory and immediate reporting requirements of alleged abuse or neglect as appropriate to their respective roles.

B) Conduct audits for a period of four weeks to ensure that all incidents (if any) of alleged abuse or neglect are reported immediately to the Director either through the Critical Incident System during business hours or the Ministry's After Hours

pager is contacted immediately during non-business hours and a Critical Incident report is submitted the following business day.

C) Take corrective actions if any deviations from the mandatory reporting requirements of abuse or neglect are identified during the audits required in section (B) to ensure compliance with the applicable legislation;

D) Keep a written record for the requirements specified in sections (A), (B), and (C) of this order.

Grounds
#1
The licensee has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident had occurred shall immediately report the suspicion and the information upon which it is based to the Director.

Rationale and Summary
Progress notes indicated that on a specific date in October 2023, a resident refused to take their medication by mouth. The resident's Substitute Decision Maker (SDM) was notified and when they arrived at the home, they forced the resident to take their medication. Registered Practical Nurse (RPN) confirmed that they were present when the incident happened.

No Critical Incident System (CIS) report was submitted by the home following the incident on the specific date.

Acting Director of Care (DOC) confirmed that the incident should have been reported to the Director and it was not.

Sources: Resident's progress notes, interview with the Acting DOC
[000727]

#2
The licensee has failed to ensure that allegations of neglect were reported immediately to the Director.

Rationale and Summary
On a specific date, during a shift, charge Registered nurse (RN) was made aware of allegations of neglect to three residents against a RPN. The charge RN stated that after being notified of the allegations that they did not call the on-call manager to report allegations of neglect. The charge RN also stated they did not call Ministry of Long-Term Care's After Hours line to report the allegations. The RCC stated that the charge RN should have called the on-call manager once they were made aware of allegations of neglect made against the RPN. Acting DOC stated that during non-business hours, the RN must call the on-call manager to ensure that immediate reporting requirements are met for allegations of neglect.

By not ensuring that allegations of neglect were reported immediately to the Director, three residents were not provided all regulatory compliance resources to ensure their safety and quality of life.

Sources: Interviews with registered staff member, RCC, and Acting DOC; Critical Incident
[740785]

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#3
The licensee has failed to ensure that an incident of alleged neglect was reported to the Director.

Rationale and Summary
On a specific date, a Personal Support Worker (PSW) reported via email to RCC concerns regarding a RPN's care of a resident and not providing pain management to the resident. The charge RN from that shift stated that the PSW reported multiple allegations of improper care and neglect by a RPN to multiple residents, including another resident, after the PSW's shift had finished on a specific date. The Acting DOC stated that any staff members that become aware of any allegations of abuse or neglect must report these allegations to the RN during non-business hours on-shift and immediately to ensure mandatory reporting requirements are met.

Review of Critical Incident (CI) and the CI database on ltchomes.net by Inspector #740785 showed no report of a specific incident of neglect related to a resident on or after the date of occurrence.

By not ensuring that an incident of alleged neglect was reported to the Director immediately, a resident was put at risk of not receiving adequate regulatory resources to ensure their safety and quality of life.

Sources: Interviews with registered staff member and Acting DOC; Employer Investigation Report for an incident on a specific date in October 2023 conducted by RCC; CI report; CI database on ltchomes.net
[740785]

This order must be complied with by February 9, 2024

COMPLIANCE ORDER CO #003 Required programs

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

A) Provide education to a registered staff member on the correct implementation of the Head Injury Routine (HIR) as specified in the home's policy;

B) For a period of four weeks, the home shall conduct audits for all fall incidents that occur in the home that require the HIR to ensure that the required assessments are being performed and documented as specified in the home's policy;

C) Corrective action shall be taken for any deviation from the home's HIR policy identified during the audits;

D) A written record shall be kept for all the requirements specified in sections (A), (B), and (C) of this order.

Grounds
#1
The licensee has failed to ensure that the Falls Prevention and Management policy was complied with for a resident. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury, and it must be complied with.

Rationale and Summary
Specifically, staff did not comply with the Head Injury Routine (HIR) policy, which was included in the licensee's Falls Prevention and Management Program.

The HIR directed the staff to follow these parameters after an unwitnessed fall: residents must be assessed every 30 minutes for two hours, every hour for six hours, every four hours for eight hours and then every eight hours for 72 hours post head injury.

On a specific date, a resident sustained an unwitnessed fall and was placed on the HIR. The HIR assessment tool was not completed as per parameters, five hourly assessment were not completed. The resident had a second fall and a new HIR was not initiated.

A Registered Practical Nurse (RPN) acknowledged that HIR assessments were missing. A Registered staff member and Acting Administrator acknowledge that if a resident is already on a HIR and has a second unwitnessed fall a new HIR should be initiated.

As such, a resident was at risk of neurological changes going unidentified due to follow-up assessments not being completed and documented.

Sources: A resident's health records, HIR policy N-100 last reviewed May 26, 2023, Interview with registered staff members and acting Administrator.
[000727]

#2
The licensee has failed to ensure that the homes fall prevention and management program was complied with. Specifically, a registered staff member failed to ensure they completed the Head Injury Routine (HIR) assessments as specified in the policy. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee was required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury, and it must be complied with.

Rationale and Summary
On a specific date, a resident sustained an unwitnessed fall and was placed on the Head Injury Routine for evaluating the resident's neurological status as required by the home's Fall Prevention and Management Program. A RPN was responsible for performing assessments for a resident as part of the HIR. A review of the resident's progress notes from the specific shift revealed no progress notes for the resident. RCC stated that the RPN did not wake the resident during the shift to perform assessments as part of the HIR and the registered staff member did not document a progress note on the resident as is required for every shift as part of the HIR policy. A registered staff member and RCC both stated that residents must be woken for their assessments as part of the HIR. Per the home's Standard Operating Procedure: Head Injury Routine (SOP #: N-100), a progress note must be made at the end of each shift for residents on the HIR.

In the home's investigation notes of the incident, in the interview of the RPN conducted by RCC, the RPN stated they did not wake the resident to perform their assessments as part of the HIR during their shift.

By not ensuring that a progress note was documented on a resident on a specific date, a resident's status throughout the shift was not communicated to the oncoming staff. By not ensuring that a resident was woken for assessments as part of the HIR, a resident was placed at risk of having an unidentified change in their level of consciousness.

Sources: Interviews with registered staff member and RCC; Resident's electronic medical record; The home's investigation interview of a RPN. Standard Operating Procedure: Head Injury Routine (SOP #: N-100) last reviewed May 2023.
[740785]

#3
The licensee has failed to ensure that the homes fall prevention and management program was complied with. Specifically, a RPN failed to ensure they completed the Head Injury Routine (HIR) assessments for a resident as specified in the policy. In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury, and it must be complied with.

Rationale and Summary
On a specific date, a resident sustained an unwitnessed fall and was placed on the Head Injury Routine for evaluating the resident's neurological status as required by the home's Fall Prevention and Management Program. On a specific date, a RPN was responsible for performing these assessments every hour for a resident. The HIR from a specified date indicated that a resident required hourly fall assessments during specified date. The RPN responsible for assessing the resident on the HIR documented hourly that the resident was sleeping. A RN stated that any residents on the HIR must be woken for hourly assessments to assess for any changes in their

neurological status. the RCC stated that the RPN did not perform the hourly checks on the resident as required by the HIR policy. Per the home's Standard Operating Procedure: Head Injury Routine (SOP #: N-100), residents must be assessed every 30 minutes for two hours, then every one hour for six hours after a fall has occurred and that only an RN has the discretion to change these intervals.

In the home's investigation notes of the incident, in the interview of the registered staff member conducted by RCC, the RPN stated they did not wish to wake the resident for an HIR assessment and they had not consulted with the RN regarding changing the intervals in the resident's HIR.

By not ensuring that a resident was woken hourly at the time intervals specified by the home's HIR procedure, a resident was placed at risk of having unidentified changes in their neurological status.

Sources: HIR form for a resident; Interviews with registered staff member and RCC; The home's investigation interview of the registered staff member conducted in September 2023. Standard Operating Procedure: Head Injury Routine (SOP #: N-100) last reviewed May 2023.
[740785]

This order must be complied with by February 9, 2024

COMPLIANCE ORDER CO #004 Safe storage of drugs

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,

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(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

A) Provide education to two Registered Practical Nurses (RPN) related to all of the home's policies related to the safe storage of medications in the home.

B) For a period of four weeks, audits will be conducted, at a minimum, four times per week to ensure that medication carts are locked when not being used by a member of the registered nursing staff. Audits must be completed on a morning, lunchtime, evening, and night time medication pass each week. At a minimum, two units must be audited for each required audit. All units must be audited at a minimum once per week.

C) For a period of four weeks, audits will be conducted, at a minimum, four times per week to ensure that topical prescription medications are locked in the medication room when not being used by a member of the registered nursing staff. At a minimum, two units must be audited for each required audit. All units must be audited at a minimum once per week.

D) Corrective action must be taken if any deviation from the home's policies and procedures related to the safe storage of medications is determined.

E) A written record must be kept for requirements outlined in sections (A), (B), (C), and (D) of this order.

Grounds
#1
The licensee has failed to ensure that drugs are stored in an area that is secure and locked.

Rationale and Summary
Topical prescription medications were observed during the inspection, in the open nursing station on a specific unit on the third floor, unsupervised. A RPN stated that topical prescription medications are to be stored and locked in the medication room. The Acting DOC stated that topical prescription medications are to be stored and locked in the medication room when not in use.

By not ensuring that topical prescription medications were stored in a secure and locked area, residents were put at risk of accessing mediations not prescribed to them.

Sources: Observations of topical prescription medications on a specific unit during the inspection; Interviews with RPN and Acting DOC
[740785]

#2
The licensee has failed to ensure that the drugs for a specific unit, were stored in a medication cart that was secure and locked.

Rational and Summary
During the inspection, the inspector observed a medication cart, on a specific unit that was unlocked. There was no registered staff observed in the immediate vicinity. A RPN confirmed that they were on duty and acknowledged that the cart had been

left open. The RPN also confirmed that they had gone to the nursing office from which they were unable to see the cart.

In an interview with a RN confirmed that when the medication cart is outside the medication room, but it is not in use, the RPN is expected to lock the medication cart. The Acting Director of Care confirmed that when the medication cart was outside the medication room but was not in use, the RPN's are expected to lock the medication cart.

Failure to ensure the medication cart is secure and locked poses a risk of having residents access medications for which they are not prescribed.

Sources: Inspector observation of specific unit, interview with registered staff members and Acting DOC
[000731]

This order must be complied with by February 9, 2024

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director’s review decision, issued under section 169 of the Act, with respect to an inspector’s compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.