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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 21, 2020	2020_661683_0001	013956-19, 021445-19, 021446-19, 021959-19, 022937-19, 023340-19, 023411-19, 023413-19, 023439-19, 023805-19, 000137-20, 000781-20	Critical Incident System

Licensee/Titulaire de permis

St. Joseph's Health System
50 Charlton Avenue East Room M146 HAMILTON ON L8N 4A6

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

St. Joseph's Villa, Dundas
56 Governor's Road DUNDAS ON L9H 5G7

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

LISA BOS (683), STACEY GUTHRIE (750)

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): January 7, 8, 9, 10, 13, 15, 16, 17, 20, 21, 22, 23, 24, 27, 28, 29, 30 and 31, 2020.

This inspection was completed concurrently with complaint inspection #2020_661683_0002 and director order follow up inspection #2020_661683_0003.

The following intakes were completed during this critical incident inspection:
Log #013956-19 was related to falls prevention and management
Log #021959-19 was related to responsive behaviours
Log #022937-19 was related to falls prevention and management
Log #023340-19 was related to falls prevention and management
Log #023411-19 was related to medication administration
Log #023413-19 was related to falls prevention and management
Log #023805-19 was related to falls prevention and management
Log #000137-20 was related to medication administration
Log #000781-20 was related to medication administration

The following follow up inspections were completed concurrently with this critical incident inspection:
Log #023439-19 was related to CO #001 from inspection #2019_661683_0021 regarding O. Reg. 79/10 s. 134
Log #021446-19 was related to CO #004 from inspection #2019_560632_0020 regarding O. Reg. 79/10 s. 135 (1)
Log #021445-19 was related to CO #007 from inspection #2019_560632_0020 regarding O. Reg. 79/10 s. 131 (2)

PLEASE NOTE:
A Written Notification (WN) and Voluntary Plan of Correction (VPC) related to O. Reg. 79/10 s. 8 (1) (b) were identified in this inspection and have been issued in inspection report #2020_661683_0002, which was conducted concurrently with this inspection.

A WN and Compliance Order (CO) related to O. Reg. 79/10 s. 131 (2) and s. 135 (1), identified in concurrent inspection #2020_661683_0002 were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Quality, Performance Systems and Food Services, the Director(s) of Care (DOC), the Assistant Director(s) of Care (ADOC), the Resident Care Managers (RCM), the Education, Quality and Clinical Support Lead, the Resident Assessment Instrument (RAI) Coordinator(s), the Physician, the Physiotherapist (PT), the

Registered Dietitian (RD), registered staff, Personal Support Workers (PSW), residents and families.

During the course of the inspection, the inspector(s) reviewed resident clinical records, reviewed policies and procedures, reviewed investigation notes, reviewed training records, reviewed internal audits and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 134.	CO #001	2019_661683_0021	750

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 :

1. The licensee has failed to ensure that drugs were administered to residents in

accordance with the directions for use specified by the prescriber.

A) Compliance Order (CO) #007 from inspection #2019_569632_0020 required the home to complete an audit for drug administration.

i) A review of the home's Focused Audit Tools for drug administration identified a medication incident involving resident #002.

A review of resident #002's clinical record identified a change in their medication on an identified date. Several days later, a discrepancy was found by RPN #107, who then clarified the order with the physician, and the order was corrected.

In an interview with RPN #107, they indicated that there was a transcription error related to resident #002's medication, and staff would have been administering the incorrect dose since it was transcribed.

In an interview with ADOC #109, they confirmed resident #002's medication was not administered in accordance with the directions for use specified by the prescriber.

ii) A review of resident #003's eMAR identified that they had an order for an identified medication. A progress note identified an incident where resident #003 was only administered a partial dose of the medication. It was also noted that other staff had similar experiences and RN #105 stated that the resident had not been receiving the medication.

In an interview with RN #105, they confirmed that they only administered a partial dose to resident #003 for the indicated order.

In an interview with RCM #117, they confirmed that the medication was not administered to resident #003 on in accordance with the directors for use specified by the prescriber.

This finding will serve as further evidence to support CO #007 issued on November 6, 2019, from inspection #2019_560632_0020, with a compliance due date of November 29, 2019.

iii) A review of the home's medication incident binder identified an incident where resident #010 did not receive their ordered medication for several days after admission to the home.

A review of the clinical record for resident #010 indicated that upon admission, all medications were confirmed. Several days later, RPN #103 discovered that the resident's medication was not processed in Point Click Care (PCC).

In an interview with RPN #103, they indicated that they discovered the resident's medication was not processed and therefore would not have been in the eMAR. RPN #103 confirmed that resident #010 did not receive their ordered medication for several days.

This finding will serve as further evidence to support CO #007 issued on November 6, 2019, from inspection #2019_560632_0020, with a compliance due date of November 29, 2019.

B) A complaint was submitted to the Director regarding concerns about the management of medication orders in the home resulting in possible medication omissions.

i) Resident #013's eMAR was reviewed and identified the resident was receiving an ordered medication twice daily from an identified date. Later that month, a change in medication was noted and included an order to increase the dose of medication. Resident #013's eMAR found no documentation for the administration of the medication on three occasions.

In an interview with RPN #128, they indicated that on an identified date, they administered the previous order, as the new order was not processed at the time of administration.

In an interview with RPN #130, they acknowledged that they worked an identified shift and indicated that they did not recall administering the medication to resident #013 and acknowledged that it was not documented as given on the eMAR.

A progress note indicated that RPN #129 administered the previous order to resident #013.

In an interview with RCM #127, they confirmed that resident #013 was not administered the medication in accordance with the directions for use by the specified prescriber on three occasions.

ii) Resident #014's eMAR and Medical Pharmacies' Combined Monitored Medication Record with Shift Count were reviewed, and it was identified that they received a medication two times a day. On an identified date, a change was ordered to decrease the medication. There was no documentation that they received a dose of the medication on two occasions.

In interviews with RPNs #127 and #130, they acknowledged that they did not administer the medication to resident #014 during their shift on the identified dates.

In an interview with RCM #127, they confirmed that resident #014 was not administered the medication as ordered on two dates, which was not in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was, documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and reported to the resident, the resident's substitute decision maker, if any, the Director of Nursing and

Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A) Resident #003's written plan of care was reviewed and through the eMAR and associated progress notes, it was identified that resident #003 received a partial dose of an ordered medication.

The medication incident binder for 2019 was reviewed and no evidence of the noted incident was found reported in the binder.

In an interview with RN #105, they confirmed that they only administered a partial dose to resident #003 for the indicated order. They explained that they informed the RCM and ADOC after the incident and acknowledged that they did not complete a medication incident report and they should have.

In an interview with RCM #117, they acknowledged a partial dose would be considered an omission and met the definition of a medication incident. They also noted that a medication incident report should be completed following a medication omission.

This finding will serve as further evidence to support CO #004 issued on November 6, 2019, from inspection #2019_560632_0020, with a compliance due date of November 29, 2019.

B) A complaint was submitted to the Director regarding concerns about the management of medication orders in the home resulting in possible medication omissions.

i) Resident #013's eMAR was reviewed and identified the resident was receiving an ordered medication twice daily from an identified date. Later that month, a change in medication was noted and included an order to increase the dose of medication. Resident #013's eMAR found no documentation for the administration of the medication on three occasions.

In an interview with RPN #128, they indicated that on an identified date, they administered the previous order, as the new order was not processed at the time of administration.

In an interview with RPN #130, they acknowledged that they worked an identified shift

and indicated that they did not recall administering the medication to resident #013 and acknowledged that it was not documented as given on the eMAR.

A progress note indicated that RPN #129 administered the previous order to resident #013.

The Medication Incident binder was reviewed, and no reports were found regarding any of the three medication incidents noted above involving resident #013.

In an interview with RCM #127, they confirmed that not administering medication as ordered by the prescriber was an omission and would require a medication incident report to be completed as a result. RCM #127 also acknowledged that administering the incorrect dose of medication would be a medication incident and required medication incident reporting.

The home failed to ensure that the medication incidents involving resident #013 were documented.

ii) Resident #014's eMAR was reviewed for an identified month and it identified that the resident was receiving an identified medication. On an identified date, a change was ordered to decrease the medication. As per the eMAR, resident #014 did not receive a dose of the medication on two identified dates, after the change was ordered.

The Medical Pharmacies' Combined Monitored Medication Record with Shift Count were reviewed for resident #014 and there was no evidence of a dose administered to resident #014 on the two identified dates, as ordered.

In interviews with RPNs #127 and #130, they acknowledged that they did not administer the medication to resident #014 during their shift on the identified dates.

The Medication Incident binder was reviewed, and no reports were found regarding the incident involving resident #014 missing two doses of an ordered medication.

In an interview with RCM #127, they confirmed that resident #014 was not administered the medication on two identified dates, which were both omissions and required a medication incident report to be completed.

The home failed to ensure that the medication incident involving resident #014 was

documented following medication omissions on two dates. [s. 135. (1)]

Additional Required Actions:

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

WN #3: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for residents #008 and #009 were provided to them as specified in the plan.

A) A Critical Incident (CI) report was submitted to the Director related to a fall for resident #008 which resulted in a significant change in condition.

A review of the clinical record for resident #008 identified that they were at a risk of falls and they had various fall prevention interventions in place.

In an interview with resident #008, they indicated that a specific fall prevention intervention was not in place, which was confirmed by observation by Inspector #683. In an interview with RPN #122 and PSW #123, they identified that the fall prevention intervention was on hold for a period of time, but RPN #122 acknowledged that the hold was no longer indicated, and that the intervention should have been in place.

In an interview with RCM #126, they agreed that the identified fall prevention intervention was indicated given the resident's recent fall.

The home did not ensure that resident #008's fall prevention intervention was in place, as per their written plan of care.

B) A CI report was submitted to the Director related to a fall for resident #009 which resulted in a significant change in condition.

A review of the clinical record for resident #009 identified that they were at risk of falls and had various interventions in place to try and prevent falls.

Resident #009 was observed on two occasions and three of their fall prevention interventions were not in place as per their written plan of care.

The home did not ensure that three of resident #009’s fall prevention interventions were in place as per their written plan of care. [s. 6. (7)]

Issued on this 25th day of February, 2020

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	LISA BOS (683), STACEY GUTHRIE (750)
Inspection No. / No de l’inspection :	2020_661683_0001
Log No. / No de registre :	013956-19, 021445-19, 021446-19, 021959-19, 022937-19, 023340-19, 023411-19, 023413-19, 023439-19, 023805-19, 000137-20, 000781-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 21, 2020
Licensee / Titulaire de permis :	St. Joseph's Health System 50 Charlton Avenue East, Room M146, HAMILTON, ON, L8N-4A6
LTC Home / Foyer de SLD :	St. Joseph's Villa, Dundas 56 Governor's Road, DUNDAS, ON, L9H-5G7
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Mieke Ewen

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 St. Joseph's Health System, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_560632_0020, CO #007;

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 :

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

Specifically, the licensee must:

1. Ensure that residents #002, #013, #014 and all other residents are administered drugs in accordance with the directions for use specified by the prescriber.

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order (CO) #007 from inspection #2019_560632_0020 issued on November 6, 2019, with a compliance due date of November 29, 2019.

The licensee must be compliant with O. Reg. 79/19, s. 131. (2).

Specifically, the licensee must:
1. Ensure that drugs are administered to residents #074 and #076 and all other residents in accordance with the directions for use specified by the prescriber.
2. Conduct an audit to ensure that drugs are administered to residents #074 and #076 and all other residents in accordance with the directions for use specified by the prescriber.
3. Keep documentation records of the audits conducted to ensure that drugs are administered to residents #074 and #076 and all other residents in accordance with the directions for use specified by the prescriber.

The licensee completed steps 2 and 3 in CO #007.

The licensee failed to complete step 1 regarding medication being administered to residents in accordance with the direction for use.

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

A) Compliance Order (CO) #007 from inspection #2019_569632_0020 required the home to complete an audit for drug administration.

A review of the home's Focused Audit Tools for drug administration identified a medication incident involving resident #002.

A review of resident #002's clinical record identified a change in their medication on an identified date. Several days later, a discrepancy was found by RPN #107, who then clarified the order with the physician, and the order was corrected.

In an interview with RPN #107, they indicated that there was a transcription error related to resident #002's medication, and staff would have been administering the incorrect dose since it was transcribed.

In an interview with ADOC #109, they confirmed resident #002's medication was not administered in accordance with the directions for use specified by the prescriber.

B) A complaint was submitted to the Director regarding concerns about the management of medication orders in the home resulting in possible medication omissions.

i) Resident #013's eMAR was reviewed and identified the resident was receiving an ordered medication twice daily from an identified date. Later that month, a change in medication was noted and included an order to increase the dose of medication. Resident #013's eMAR found no documentation for the administration of the medication on three occasions.

In an interview with RPN #128, they indicated that on an identified date, they administered the previous order, as the new order was not processed at the time of administration.

In an interview with RPN #130, they acknowledged that they worked an identified shift and indicated that they did not recall administering the medication to resident #013 and acknowledged that it was not documented as given on the eMAR.

A progress note indicated that RPN #129 administered the previous order to resident #013.

In an interview with RCM #127, they confirmed that resident #013 was not administered the medication in accordance with the directions for use by the specified prescriber on three occasions.

ii) Resident #014's eMAR and Medical Pharmacies' Combined Monitored Medication Record with Shift Count were reviewed, and it was identified that they received a medication two times a day. On an identified date, a change was ordered to decrease the medication. There was no documentation that they received a dose of the medication on two occasions.

In interviews with RPNs #127 and #130, they acknowledged that they did not administer the medication to resident #014 during their shift on the identified dates.

In an interview with RCM #127, they confirmed that resident #014 was not administered the medication as ordered on two dates, which was not in accordance with the directions for use specified by the prescriber.

The severity of this issue was a level 2 as there was minimal harm to the residents. The scope was level 3 as it related to five of five residents reviewed. The home had a level 5 compliance history as they had ongoing non-compliance with this section of O. Reg. 79/10 and four or more compliance orders that included:
• Voluntary Plan of Correction (VPC) issued October 26, 2017 (2017_542511_0011);

• VPC issued November 10, 2017 (2017_569508_0013);
• VPC issued July 13, 2018 (2018_659586_0014);
• Compliance order (CO) #007 served on November 6, 2019 (2019_560632_0020).
Additionally, the LTCH has a history of 26 compliance orders to other subsections in the last 36 months. (750)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 002

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

Linked to Existing Order / Lien vers ordre existant: 2019_560632_0020, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Order / Ordre :

The licensee must be compliant with s. 135. (1) of O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure that every medication incident involving resident #013, #014 and all other residents is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and is reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order (CO) #004 from inspection #2019_560632_0020 issued on November 6, 2019, with a compliance due date of November 29, 2019.

The licensee must be compliant with O. Reg. 79/19, s. 135. (1).

Specifically, the licensee must:

1. Ensure that every medication incident involving residents #021 and #076 and all other residents is documented, together with a record of the immediate actions taken to assess and maintain the residents health and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.
2. Ensure that all registered staff are provided education related to need complete Medication Incidents Reports for all medication incidents and ensure that a written record of staff attendance is maintained in the home.

The licensee completed step 2 in CO #004.

The licensee failed to complete step 1 regarding the documentation of the associated steps involving medication incidents.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was, documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and reported to the resident, the resident's substitute decision maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A) A complaint was submitted to the Director regarding concerns about the management of medication orders in the home resulting in possible medication omissions.

i) Resident #013's eMAR was reviewed and identified the resident was receiving an ordered medication twice daily from an identified date. Later that month, a change in medication was noted and included an order to increase the dose of medication. Resident #013's eMAR found no documentation for the administration of the medication on three occasions.

In an interview with RPN #128, they indicated that on an identified date, they administered the previous order, as the new order was not processed at the time of administration.

In an interview with RPN #130, they acknowledged that they worked an identified shift and indicated that they did not recall administering the medication to resident #013 and acknowledged that it was not documented as given on the eMAR.

A progress note indicated that RPN #129 administered the previous order to resident #013.

The Medication Incident binder was reviewed, and no reports were found regarding any of the three medication incidents noted above involving resident #013.

In an interview with RCM #127, they confirmed that not administering medication as ordered by the prescriber was an omission and would require a medication incident report to be completed as a result. RCM #127 also acknowledged that administering the incorrect dose of medication would be a medication incident and required medication incident reporting.

The home failed to ensure that the medication incidents involving resident #013 were documented.

ii) Resident #014's eMAR was reviewed for an identified month and it identified that the resident was receiving an identified medication. On an identified date, a change was ordered to decrease the medication. As per the eMAR, resident #014 did not receive a dose of the medication on two identified dates, after the change was ordered.

The Medical Pharmacies' Combined Monitored Medication Record with Shift Count were reviewed for resident #014 and there was no evidence of a dose administered to resident #014 on the two identified dates, as ordered.

In interviews with RPNs #127 and #130, they acknowledged that they did not

administer the medication to resident #014 during their shift on the identified dates.

The Medication Incident binder was reviewed, and no reports were found regarding the incident involving resident #014 missing two doses of an ordered medication.

In an interview with RCM #127, they confirmed that resident #014 was not administered the medication on two identified dates, which were both omissions and required a medication incident report to be completed.

The home failed to ensure that the medication incident involving resident #014 was documented following medication omissions on two dates.

The severity of this issue was a level 2 as there was minimal harm to the residents. The scope was level 3 as it related to three of three residents reviewed. The home had a level 5 compliance history as they had ongoing non-compliance with this section of O. Reg. 79/10 and four or more compliance orders that included:
• Written Notification (WN) issued October 26, 2017 (2017_542511_0011);
• Voluntary Plan of Correction (VPC) issued November 22, 2019 (2019_661683_0021);
• Compliance Order (CO) #004 served on November 6, 2019 (2019_560632_0020).
Additionally, the LTCH has a history of 26 compliance orders to other subsections in the last 36 months. (750)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 21st day of February, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Bos

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