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

London Service Area Office
130 Dufferin Avenue 4th floor
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 05, 2022	2021_928577_0003 (A1)	012853-21, 015821-21, 017355-21, 017485-21, 017577-21, 017614-21	Complaint

Licensee/Titulaire de permis

Henley Place Limited
200 Ronson Drive Suite 305 Toronto ON M9W 5Z9

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

Henley Place
1961 Cedarhollow Boulevard London ON N5X 0K2

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

Amended by DEBBIE WARPULA (577) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee requires additional time to achieve compliance. The CDD has changed to February 11, 2022.

Issued on this 5 th day of January, 2022 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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1961 Cedarhollow Boulevard London ON N5X 0K2

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

Amended by DEBBIE WARPULA (577) - (A1)

Amended 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): October 18 to 22, 25 to 29, and November 1 to 4, 2021.

The following intakes were inspected on during this Complaint inspection:

-one intake related to alleged neglect of residents, medication concerns and staffing concerns;

-one intake related to a fire in the home;

-one intake related to alleged neglect of a resident;

-one intake related to alleged neglect of a resident;

-one intake related to medication concerns; and

-one intake related to alleged neglect of a resident.

Follow Up inspection #2021_928577_0004, and Critical Incident Inspection #2021_928577_0002, were conducted concurrently with this Complaint inspection.

A finding of non-compliance related to s.8 (1) b and s. 76 (2) 7 of the Long-Term Care Homes Act, 2007, identified in concurrent CIS #2021_928577_0002 was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Acting Director of Care (ADOC), Assistant Director of Care (ADOC), two Primacare Nursing Consultants, Environmental Services Manager (ESM), Housekeeping Supervisor, Registered Nurses (RNs), Registered Practical Nurses (RPNs), the Consultant Geriatrx Pharmacist and family members.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Safe and Secure Home

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

- **5 WN(s)**
- **3 VPC(s)**
- **3 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 there was a written plan of care for two residents which set out clear direction to staff and others regarding the provision of a specific treatment.

A resident's clinical records identified in their orders in Point Click Care (PCC), a specific treatment with specific parameters and the progress notes identified “according to Respiratory therapist resident should be on the specific treatment continuously”. The resident had no direction in their care plan related to the specific treatment.

Another residents clinical record, identified in their orders in PCC, a specific treatment with specific parameters, the Electronic Medication Administration Record (eMAR) identified a specific treatment to maintain a certain parameter. The resident had no direction in their care plan related to the specific treatment.

An Registered Practical Nurse (RPN) and Acting Director of Care (ADOC) stated that the two residents were on a specific treatment, however, the treatment was not included in their care plans but should have been. Acting DOC stated that clear direction was not provided to the staff.

The home's policy stated that for residents on a specific treatment, it was to be documented in the care plan, minimum data set (MDS) and progress notes.

There was minimal risk to the two residents as they could have received inappropriate treatment due to unclear direction in the care plan.

Sources: The home's Oxygen Policy (#04-29), two resident's clinical records, including orders, progress notes, care plan and Minimum Data Set (MDS), interviews with an RPN, Acting DOC and other staff. s. 6. (1) (c) [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in a resident's plan of care related to a specific treatment was provided.

A Critical Incident System (CIS) report was submitted by the home to the Director, which outlined how on an identified date, a resident's specific apparatus was found empty by family and they reported it to staff.

The resident had an order for a specific treatment, and a progress note documented that the specific treatment was empty.

An RPN stated that on an identified date, the resident's specific apparatus was empty, and it should have been full.

There was minimal risk to the resident as they were not the specific treatment as ordered.

Sources: CIS report, a resident's clinical records, including orders and progress notes, interviews with an RPN and other staff. s. 6. (7). [s. 6. (7)]

Additional Required Actions:

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

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 two residents in accordance with the directions for use specified by the prescriber.

A finding of non-compliance identified in critical incident inspection #2021_928577_0002 is being issued in this complaint inspection report.

a) The home reported a CIS to the MLTC on an identified date, which indicated a missing tablet of a specific medication on an identified date for a resident. The resident was scheduled to receive a specific dosage at two particular times. The Registered Nurse (RN) confirmed that they made a medication error and administered both dosages at the same time to the resident on an identified date.

b) A complaint was received by the MLTC related to medication administration for a resident. There was a specified number of medication errors documented in Risk Management in PCC for a resident over a three month period. Four of the errors included administering two tablets of a specific medication instead of one, as ordered. One error included a specific medication not being administered at all, and one error included administering a specific medication instead of the specific medication that was ordered. An RPN said that they found a number of the errors the following day, noting a missing dose in the medication card, as the staff were not reading the order and comparing it to the directions on the card of medications to ensure they were giving the right dose at the right time.

Sources: Risk management incident reports in PCC, medication incident reports from GeriatRx Pharmacy, health records for two resident's, resident and family interviews and staff interviews. [s. 131. (2)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was reported to the pharmacy service provider.

The licensee also failed to ensure that, all medication incidents were reviewed and analyzed; corrective action was taken as necessary; and a written record was kept of everything.

The licensee has also failed to ensure that, a quarterly review was undertaken of all medication incidents that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents; any changes and improvements identified in the review were implemented; and a written record kept of everything.

a) A medication incident report was documented in PCC for a resident on an identified date, where they received two tablets of a specific medication instead of one. The report did not indicate that the pharmacy was notified of the error. GeriatRx Pharmacist said that the pharmacy was not made aware of that medication incident. The expectation was that staff completed a medication incident report in the online portal for the pharmacy and there was none.

b) Three medication incidents documented for a resident on three identified dates, did not include any analysis of the medication incident or corrective action taken in the medication incident form in risk management or in a medication incident form submitted to pharmacy.

c) The Acting DOC and the Primacare Nurse Consultant said they had not completed any quarterly medication incident analyses in order to reduce and prevent medication incidents, since they started on an identified date, and were not able to find any completed before that time.

GeriatRx Pharmacy policy "Medication Incident Reporting" stated: The Medication Incident Report form is to be completed by the person discovering the incident, then reviewed and completed by Facility Management. If the incident was related to an improper action, or inaction, by a member of the nursing staff, there would be a response by the facility management. The incident must be placed on the agenda for discussion at the next Pharmacy and Therapeutics Committee meeting or Medical Advisory Committee Meeting.

Sources: Health records for a resident, medication incident reports in Risk Management in Point Click Care, GeriatRx Pharmacy Medication Incident Reports, GeriatRx Pharmacy policy Medication Incident Reporting (#6.04, effective August 27, 2020), and staff interviews. [s. 135.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that policies related to Drill Documentation, Fire Preparedness and Fire Emergency Response, were complied with.

O. Reg. 79/10, s. 230 (1) (4) requires that the emergency plans required under subsection 87 (1) of the Act, provide for dealing with fires, and s. 230 (1) (5) (4) requires that the emergency plans address specific staff roles and responsibilities.

a) A CIS report was received by the MLTC concerning a fire in the home on an identified date. The report indicated that an RPN saw smoke coming from a particular apparatus where they were heating food, and ran down the hallway, leaving three residents in that room.

A complaint and a CIS report were received by the MLTC concerning a fire in the home on another identified date. The complaint alleged that on that day, there were firetrucks on the premises, no one was in charge, was aware of what to do or had knowledge of the home's evacuation plans.

A review of the home's policy "Emergency Response Captain/Fire Warden - #03-05" effective October 2011, and "Fire Preparedness - #03-09" effective October 2011, indicated that during a fire, staff were to respond according to REACT-Remove those in immediate danger, ensure that the room door was closed, activate fire alarm, call the Fire Department and try to extinguish or contain the fire.

During an interview with the RPN, they advised that they should have taken the residents out of the room first, but they left the room and ran down the hall to get help. Advised that they should have responded with REACT, by first removing the

residents from the room with the smoking apparatus.

During an interview with the Executive Director (ED), they advised that the RPN should have immediately removed the residents from the room (REACT), as per policy.

b) A review of the home's policy "Drill Documentation - #03-36" effective January 2014, indicated that a 'Fire Alarm Report' must be completed each and every time the fire alarm sounds. All staff in attendance at the time of an emergency fire drill, would sign the 'Record of Fire Drill' attendance form.

During an interview with Environmental Services Manager (ESM) they advised that a specific form should have been filled out by the Registered Nurse (RN) on the identified date, the day of the fire, and had not.

Inspector #577 reviewed the specific forms for an identified date, received by the ESM and found that a specific number of reports were not documented in entirety as per policy.

During an interview with the ESM and the ED, they confirmed that in both fire incidents, staff had not documented on the specific forms and attendance as required.

Sources: two Critical Incident System (CIS) reports, a complaint, the home's policy Emergency Response Captain/Fire Warden (#03-05 effective October 2011), Fire Preparedness (#03-09 effective October 2011), Drill Documentation (#03-36 effective January 2014), reviews of Fire Drill Reports and attendance records, training records, interviews with ESM and other staff. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that RN #127 received training for their role and responsibility on Fire prevention and safety.

A complaint and a CIS report was received by the MLTC concerning a fire in the

home on an identified date. The complaint alleged that on that day, there were firetrucks on the premises, no one was in charge, was aware of what to do or had knowledge of the home's evacuation plans.

A review of the home's policy "Emergency Preparedness - 16-01" effective November 2011, indicated that training and education were essential components of the Emergency Preparedness Program and staff required initial and ongoing training to become fully aware of procedures in the event of an emergency situation. The administrator would ensure that staff received training at orientation and annually and have the opportunity at minimum annually to practise fire procedures and evacuation.

A review of the home's policy "Fire Preparedness - Minimum Training Components - 03-25" revised October 2011, indicated that all new staff must receive orientation to and understand the Fire Preparedness Plan for the home and specific areas applicable to their area of work.

During an interview with the Housekeeping Supervisor and the ESM, they reported that a staff member turned on a specific apparatus while there was food inside which caused a fire. They advised that an RN was the charge nurse that day and wasn't aware of what to do in a fire emergency and had not assisted at all.

During an interview with the RN they reported that they had no specific training on what their role and responsibility was in respect to a fire emergency. Advised that they called the on-call manager to ask for direction.

In an interview with the ED, they advised that the RN didn't know their role during a fire and it was expected that during training, they should have been trained by another RN or ESM on RN responsibilities during a fire.

Sources: Critical Incident System report, a complaint, the home's Emergency Preparedness policy (#16-01, effective November 2011), Fire Preparedness - Minimum Training Components (03-25, effective October 2011), training records, and interviews with an RN and other staff. [s. 76. (2) 7.]

Additional Required Actions:

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

Issued on this 5 th day of January, 2022 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by DEBBIE WARPULA (577) - (A1)
Inspection No. / No de l'inspection :	2021_928577_0003 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	012853-21, 015821-21, 017355-21, 017485-21, 017577-21, 017614-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 05, 2022(A1)
Licensee / Titulaire de permis :	Henley Place Limited 200 Ronson Drive, Suite 305, Toronto, ON, M9W-5Z9
LTC Home / Foyer de SLD :	Henley Place 1961 Cedarhollow Boulevard, London, ON, N5X-0K2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Denise Bedard

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 Henley Place Limited, 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

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee must be compliant with s. 6. (1) (c) of the Long-Term Care Homes Act, 2007.

Specifically, the licensee must:
-implement the specific treatment interventions included in resident's plan of care
-update two resident's care plans to include the specific treatment
-implement strategies that will ensure that the written plan of care for all residents are reviewed and updated to set out clear directions of the residents' planned care to staff.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written plan of care for two residents which set out clear direction to staff and others regarding the provision of a specific treatment.

A resident's clinical records identified in their orders in Point Click Care (PCC), a specific treatment with specific parameters and the progress notes identified "according to Respiratory therapist resident should be on the specific treatment continuously". The resident had no direction in their care plan related to the specific treatment.

Another residents clinical record, identified in their orders in PCC, a specific treatment with specific parameters, the Electronic Medication Administration Record (eMAR) identified a specific treatment to maintain a certain parameter. The resident had no direction in their care plan related to the specific treatment.

An Registered Practical Nurse (RPN) and Acting Director of Care (ADOC) stated that the two residents were on a specific treatment, however, the treatment was not included in their care plans but should have been. Acting DOC stated that clear direction was not provided to the staff.

The home's policy stated that for residents on a specific treatment, it was to be documented in the care plan, minimum data set (MDS) and progress notes.

There was minimal risk to the two residents as they could have received inappropriate treatment due to unclear direction in the care plan.

Sources: The home's Oxygen Policy (#04-29), two resident's clinical records, including orders, progress notes, care plan and Minimum Data Set (MDS), interviews with an RPN, Acting DOC and other staff. s. 6. (1) (c) [s. 6. (1) (c)]

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

Severity: There was minimal harm to residents

Scope: The scope of this non-compliance was a pattern as it affected two residents care plans

Compliance History: The licensee was found to be non-compliant with s. 6 (1) (c) of the Long-Term Care Homes Act, 2007, in the past 36 months, and two Voluntary Plans of Correction (VPCs) and a Compliance Order (CO) was issued in the home. (745)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 22, 2021

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

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. 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:
-develop a system to flag high risk controlled substances (similar name, same name different dose) for two residents
-provide training to registered staff on the home's policies for medication administration; specifically related to the use of appropriate identifiers according to Best Medication Practices to ensure the resident is administered medications as prescribed; and
- maintain a record of the training, what the training entailed, who completed the
training and when the training was completed.

Grounds / Motifs :

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

A finding of non-compliance identified in critical incident inspection #2021_928577_0002 is being issued in this complaint inspection report.

a) The home reported a CIS to the MLTC on an identified date, which indicated a missing tablet of a specific medication on an identified date for a resident. The resident was scheduled to receive a specific dosage at two particular times. The Registered Nurse (RN) confirmed that they made a medication error and administered both dosages at the same time to the resident on an identified date.

b) A complaint was received by the MLTC related to medication administration for a resident. There was a specified number of medication errors documented in Risk Management in PCC for a resident over a three month period. Four of the errors included administering two tablets of a specific medication instead of one, as ordered. One error included a specific medication not being administered at all, and one error included administering a specific medication instead of the specific medication that was ordered. An RPN said that they found a number of the errors the following day, noting a missing dose in the medication card, as the staff were not reading the order and comparing it to the directions on the card of medications to ensure they were giving the right dose at the right time.

Sources: Risk management incident reports in PCC, medication incident reports from GeriatRx Pharmacy, health records for two resident's, resident and family interviews and staff interviews. [s. 131. (2)]

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

Severity: There was minimal harm to residents

Scope: The scope of this non-compliance was a pattern as it affected two residents. There were a specific number of documented medication errors for one resident, and one medication error for another resident.

Compliance History: The licensee was found to be non-compliant with s. 131 (2) of O. Reg. 79/10 in the past 36 months, and a Voluntary Plan of Correction (VPC) was issued in the home.
(213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 11, 2022(A1)

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

Order # / No d'ordre: 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Order / Ordre :

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

Specifically, the licensee must:
-ensure that every medication incident involving a resident is reported to the pharmacy service provider;
-ensure that all medication incidents are reviewed and analyzed;
-ensure that corrective action is taken;
-ensure that a quarterly review is undertaken of all medication incidents that have occurred in the home since the time of the last review to reduce and prevent medication incidents;
-ensure any changes or improvements identified in the review are implemented;
-ensure a written record is kept of everything;
-DOC or designate will audit all medication incidents to ensure they have been reported, documented and reviewed; and
-document audits, actions taken, and continue auditing until 30 consecutive days of adherence is achieved

Grounds / Motifs :

1. The licensee has failed to ensure that every medication incident involving a resident was reported to the pharmacy service provider.

The licensee also failed to ensure that, all medication incidents were reviewed and analyzed; corrective action was taken as necessary; and a written record was kept of everything.

The licensee has also failed to ensure that, a quarterly review was undertaken of all

medication incidents that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents; any changes and improvements identified in the review were implemented; and a written record kept of everything.

a) A medication incident report was documented in PCC for a resident on an identified date, where they received two tablets of a specific medication instead of one. The report did not indicate that the pharmacy was notified of the error. GeriatRx Pharmacist said that the pharmacy was not made aware of that medication incident. The expectation was that staff completed a medication incident report in the online portal for the pharmacy and there was none.

b) Three medication incidents documented for a resident on three identified dates, did not include any analysis of the medication incident or corrective action taken in the medication incident form in risk management or in a medication incident form submitted to pharmacy.

c) The Acting DOC and the Primacare Nurse Consultant said they had not completed any quarterly medication incident analyses in order to reduce and prevent medication incidents, since they started on an identified date, and were not able to find any completed before that time.

GeriatRx Pharmacy policy "Medication Incident Reporting" stated: The Medication Incident Report form is to be completed by the person discovering the incident, then reviewed and completed by Facility Management. If the incident was related to an improper action, or inaction, by a member of the nursing staff, there would be a response by the facility management. The incident must be placed on the agenda for discussion at the next Pharmacy and Therapeutics Committee meeting or Medical Advisory Committee Meeting.

Sources: Health records for a resident, medication incident reports in Risk Management in Point Click Care, GeriatRx Pharmacy Medication Incident Reports, GeriatRx Pharmacy policy Medication Incident Reporting (#6.04, effective August 27, 2020), and staff interviews. [s. 135.]

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

Severity: There was minimal harm to residents

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Scope: The scope of this non-compliance was a pattern as there was a specific number of medication incidents for a resident and half of those incidents did not include any analysis of the medication incident or corrective action taken in the medication incident form in risk management or in a medication incident form submitted to pharmacy, or a quarterly analysis

Compliance History: The licensee was found to be non-compliant with s. 135 of O. Reg. 79/10 in the past 36 months, and a Voluntary Plan of Correction (VPC) was issued in the home. (213)

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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:

Order(s) of the Inspector

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Ordre(s) de l'inspecteur

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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

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
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 5 th day of January, 2022 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by DEBBIE WARPULA (577) - (A1)

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