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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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 27, 2020 | 2020_556168_0015 | 008794-20, 011592-20 | Complaint |

### Licensee/Titulaire de permis

Blackadar Continuing Care Centre Inc.
101 Creighton Road DUNDAS ON L9H 3B7

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

Blackadar Continuing Care Centre
101 Creighton Road DUNDAS ON L9H 3B7

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

LISA VINK (168)

## 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 8, 13, 14, 16 and 19, 2020.**

**This inspection was conducted for intakes related to the prevention of abuse and neglect, specifically intakes 008794-20 and 011592-20.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, pharmacy service provider, housekeeping staff, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), program manager and residents.**

**During the course of the inspection, the inspector observed the provision of care, toured the home, reviewed relevant documents including but not limited to: procedures, program evaluations, staff human resource files, training records, investigative notes and clinical health records.**

**The following Inspection Protocols were used during this inspection:**
**Medication**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**
**Sufficient Staffing**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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 failed to ensure that the procedures in the required Medication Management System were complied with.

In accordance with O. Reg. 79/10, s. 114 (1) the licensee was required to have an interdisciplinary medication management system that provided for safe medication management and in accordance with O. Reg. 79/10, s. 114 (2), the licensee was required to ensure that written policies and protocols were developed to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

The home's procedure manual, for MediSystem, dated June 2020, included direction (s. 17.1.1) that nursing staff were responsible to discontinue medication on the Medication Administration Records, and the Physician's Digiorder form required all orders to be processed by a staff member and a second staff member to check the orders.

i. A resident was reassessed and orders were received from the physician to stop all medications, except for two specific medications.
The resident's electronic Medication Administration Record (eMAR) was reviewed the day after the reassessment and still included orders for a medication to be administered daily, in addition to two medications to be given as needed, orders which were to be discontinued based on the physician's orders.
The resident had the potential to receive medications no longer ordered for them, based on the assessment of the physician, which would be considered medication error(s).

ii. A resident received physician's orders, for the discontinuation of some medications.
A review of the eMAR identified that the orders were not fully processed, as some

discontinued medications remained active on the eMAR.
A review of the Physician's Digiorder did not include who processed the orders, only the staff member who completed the second check of the orders.
Medications which were discontinued; however, were not removed from the eMAR might had been identified and removed if staff had followed the procedure as outlined.

The medication orders were not processed according to the expectations as outlined which could have resulted in medication error(s).

Sources: Procedures for Medication Management, review of the eMAR and physician's orders for the resident and interviews with staff. [s. 8. (1) (b)]

2. The licensee failed to ensure that the procedures in the required Medication Management System were complied with.

In accordance with O. Reg. 79/10, s. 114 (1) the licensee was required to have an interdisciplinary medication management system that provided for safe medication management and in accordance with O. Reg. 79/10, s. 114 (2), the licensee was required to ensure that written policies and protocols were developed to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

The home's procedure manual, for MediSystem, dated June 2020, included direction for staff regarding medication management and the Physician's Digiorder form required all orders be processed by a staff member and a second staff member to check the orders.
The home's procedure manual, for MediSystem, dated June 2020, included direction (s. 17.1.1) that nursing staff were responsible to discontinue medication on the Medication Administration Records.
Additionally, the procedures included direction when a resident was re-admitted from the hospital (s.12.1.11) which required staff to compare previous medication orders with those currently prescribed from the hospital. Staff were to note any discrepancies in the orders, prior to receipt of readmission orders and discrepancies were to be reported to the prescriber. When staff obtained the orders they were to note if each medication was to be continued, discontinued or put on hold based on the orders received.

i. A resident was readmitted to the home from the hospital.
A review of the Re-Admission Order Form, created two days prior to readmission, which was to be a listing of all orders prior to hospitalization included an order for a medication

to be given as needed, an order not included on the resident's previous eMAR.
The medication was ordered to "continue" on the Re-Admission Order Form despite the fact that it was not a current order prior to hospitalization.
The Re-Admission Order Form did not included a signature of a second staff member to indicate that they checked the orders as required.

ii. A resident was ordered a medication to be administered once a day.
A review of the Physician's Digiorder included a signature of the staff member who processed the order, without documentation that a second staff member completed a check of the order.
The order was processed accurately.

iii. A resident was readmitted from the hospital with orders for an intervention to be administered at a dose and the frequency of once a day and as needed.
According to the Physician's Digiorder the order was changed to a different dose and frequency.
According to the record the order was processed the day after it was received, by one nurse and checked two days after it was received, by a second staff member.
A review of the eMAR, after the change in direction was received, included both the original orders for the intervention as well as the revised orders.
The eMAR did not include that the original orders were crossed out or discontinued.
When staff processed and checked the orders they did not remove discontinued orders for the intervention.
The process was not followed which resulted in errors.

The orders were not processed according to the expectations as outlined which had the potential for error(s).

Sources: Review of the eMAR and physician's orders for a resident, review of procedures for Medication Management and interviews with staff. [s. 8. (1) (b)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that care set out in the plan of care related to an intervention was provided to a resident as specified in the plan.

A resident had an order for a specific intervention to be completed daily and as needed.
The resident then received a physician's order which changed the dose of the intervention and the frequency for completion.
Staff continued to provide the intervention, at the initial dose and frequency, for five days after the order had been changed by the physician.
The Inspector confirmed that the intervention was still available, at the initial dose, for staff usage, in the medication cart, after it was changed.
The interventions continued to be administered at the incorrect dose and frequency, which was not consistent with the plan.

Sources: Physician's order and eMAR for the resident, observation and interview with staff. [s. 6. (7)]

2. The licensee failed to ensure that care set out in the plan of care, related to a treatment, was provided to a resident as specified in the plan.

A resident had an order for an intervention to be administered twice a day, which had not been put on hold or discontinued.
The intervention was not included in the resident's eMAR, as it was not processed.
It was confirmed that the resident maintained the intervention at their bedside and asked some staff to administer it, although not at the frequency prescribed. The order did not

include direction for self-administration or to remain at the bedside.
The intervention was not administered as specified in the plan.

Sources: Physician's order and eMAR for a resident, observations and interviews with the resident and staff. [s. 6. (7)]

3. The licensee failed to ensure that a resident was reassessed and the plan of care was revised at any time when the resident's care needs changed.

A resident had an activity that they had enjoyed for a long time, until a decision was made, by the home, that the activity was no longer safe due to the actions of the resident.
i. The resident was directed, by staff, to no longer conduct the activity at the home.
A review of the current care plan did not include the change in the resident's needs, as it included information related to the resident conducting the activity safely.
ii. During the inspection, following discussions it was identified that the resident's condition had improved since they were previously identified to be unsafe with the activity and they would be re-evaluated for their ability to conduct the activity safely.
The resident expressed, to the Inspector, frustration when they were not able to participate in the activity at the home.

The plan of care was not reviewed and revised when the resident's needs changed, which resulted in outdated information for staff and frustration for the resident.

Sources: Care plan, progress notes and assessments for the resident and interviews with the resident and staff. [s. 6. (10) (b)]

4. The licensee failed to ensure that a resident was reassessed and the plan of care revised at any other time when the resident's care needs changed.

A resident had a history of responsive behaviours and diagnosis.
According to the clinical record, in recent months, the resident demonstrated or reported additional behaviours or symptoms and an intervention was put in place in an effort to manage the behaviours.
A review of the current care plan noted the presence of some behaviours; however, did not include the some of the additional behaviours or symptoms noted nor the specific intervention to assist in the management behaviours.
The care plan was revised following a discussion with the staff, to include a number of

changes in care needs related to responsive behaviours.

Sources: Progress notes and care plan of the resident, and interviews staff. [s. 6. (10) (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 the care set out in the plan of care is provided to the resident as set out in the plan and that residents are reassessed and their plans of care are reviewed and revised at any time when they have a change in their care needs, to be implemented voluntarily.***

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that a resident was protected from abuse by another resident.

Residents #012 and #013 had a history of responsive behaviours and negative interactions between each other.
Resident #012 demonstrated responsive behaviours towards resident #013.
As a result of the incident, resident #013 sustained an injury which did not require medical intervention.

Sources: Progress notes and care plans of the residents, and interviews with residents and staff. [s. 19. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents are protected from abuse, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

**s. 129. (1) Every licensee of a long-term care home shall ensure that,**
**(a) drugs are stored in an area or a medication cart,**
**(i) that is used exclusively for drugs and drug-related supplies,**
**(ii) that is secure and locked,**
**(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
**(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**
**(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure a medication was stored in an area or a medication cart that was secured and locked.

A resident had an order for a medication. There was no direction for the medication to be self-administered or to be left at the bedside.
The Inspector observed, on one occasion, the medication, unattended on the resident's bedside table.
The medication was removed by staff and placed in the mediation cart following a discussion with the Inspector.
Staff confirmed that the medication should not have been left at the bedside.
The medication was not secured as required and was accessible to residents in the home during the time period.

Sources: Observations, eMAR and physician's orders for a resident and interview with staff. [s. 129. (1) (a)]

***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 medication is stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.***

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**WN #5: 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 failed to ensure that a drug was not administered to a resident in accordance with the directions for use specified by the prescriber.

A resident had an order for a medication to be given twice a day and once during the night as needed.
The medication was consistently given twice a day as ordered.
The resident was also given two additional doses of the medication, as needed, on a day, rather than only one additional dose as prescribed.
The resident was not administered the medication in accordance with the directions for use.
The administration of an additional dose of the medication was a medication error and was not consistent with the orders prescribed.

Sources: Physician's order and eMAR for the resident and interview with staff. [s. 131. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that supplies were readily available at the home to meet the nursing and personal care needs of residents.

A locked storage room contained a supply of personal hygiene items for resident use.
The area was not accessible to nursing staff outside of business hours, unless they contacted a manager to unlock the area.
On request residents were provided with hygiene supplies during business hours, and weekly clean utility rooms on each floor were provided a stock of some items.
If a resident required supplies outside of business hours they would have to wait until the next business day for supplies to be provided, unless management staff visited the home.
A tour of a clean utility room did not include any lotion, toothpaste or toothbrushes.
Staff confirmed that the items such as lotion, toothpaste and toothbrushes were not routinely stored on the resident home area and were provided on request.
Residents may not have had access to supplies to meet their hygiene needs.

Sources: Tour of a clean utility room and interviews with staff. [s. 44.]

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**Issued on this 5th day of November, 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 VINK (168) |
| **Inspection No. / No de l’inspection :** | 2020_556168_0015 |
| **Log No. / No de registre :** | 008794-20, 011592-20 |
| **Type of Inspection / Genre d’inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Oct 27, 2020 |
| **Licensee / Titulaire de permis :** | Blackadar Continuing Care Centre Inc.<br>101 Creighton Road, DUNDAS, ON, L9H-3B7 |
| **LTC Home / Foyer de SLD :** | Blackadar Continuing Care Centre<br>101 Creighton Road, DUNDAS, ON, L9H-3B7 |
| **Name of Administrator / Nom de l’administratrice ou de l’administrateur :** | Shelly Desgagne |

To Blackadar Continuing Care Centre Inc., 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

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**Order # / No d'ordre :** 001

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

**Order / Ordre :**

The licensee must be compliant with s. 8 (1) of Ontario Regulation 79/10.

Specifically the licensee must:
1. Ensure that all physician's orders are processed according to the expectations on the relevant order forms and procedures, including to ensure that one staff member processes the order(s) and a second staff member checks the order(s) and that discontinued orders are noted on the electronic Medication Administration Record (eMAR).
2. Review expectations and relevant procedures related to the processing of physician's orders with all registered staff, which includes that two staff complete the task and the discontinuation of orders on the eMAR. A written record shall be maintained which shall include: how and when the review was completed, staff who completed the review and the information provided.
3. Identify and implement a system to ensure that registered nursing staff are complying with the procedures and expectations. A written record shall be maintained of the steps and actions taken as part of the system to ensure compliance.

**Grounds / Motifs :**

1. The licensee failed to ensure that the procedures in the required Medication Management System were complied with.

In accordance with O. Reg. 79/10, s. 114 (1) the licensee was required to have

an interdisciplinary medication management system that provided for safe medication management and in accordance with O. Reg. 79/10, s. 114 (2), the licensee was required to ensure that written policies and protocols were developed to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

The home's procedure manual, for MediSystem, dated June 2020, included direction (s. 17.1.1) that nursing staff were responsible to discontinue medication on the Medication Administration Records, and the Physician's Digiorder form required all orders to be processed by a staff member and a second staff member to check the orders.

i. A resident was reassessed and orders were received from the physician to stop all medications, except for two specific medications.
The resident's electronic Medication Administration Record (eMAR) was reviewed the day after the reassessment and still included orders for a medication to be administered daily, in addition to two medications to be given as needed, orders which were to be discontinued based on the physician's orders.
The resident had the potential to receive medications no longer ordered for them, based on the assessment of the physician, which would be considered medication error(s).

ii. A resident received physician's orders, for the discontinuation of some medications.
A review of the eMAR identified that the orders were not fully processed, as some discontinued medications remained active on the eMAR.
A review of the Physician's Digiorder did not include who processed the orders, only the staff member who completed the second check of the orders.
Medications which were discontinued; however, were not removed from the eMAR might had been identified and removed if staff had followed the procedure as outlined.

The medication orders were not processed according to the expectations as outlined which could have resulted in medication error(s).

Sources: Procedures for Medication Management, review of the eMAR and

physician's orders for the resident and interviews with staff. [s. 8. (1) (b)]

(168)

2. The licensee failed to ensure that the procedures in the required Medication Management System were complied with.

In accordance with O. Reg. 79/10, s. 114 (1) the licensee was required to have an interdisciplinary medication management system that provided for safe medication management and in accordance with O. Reg. 79/10, s. 114 (2), the licensee was required to ensure that written policies and protocols were developed to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

The home's procedure manual, for MediSystem, dated June 2020, included direction for staff regarding medication management and the Physician's Digiorder form required all orders be processed by a staff member and a second staff member to check the orders.
The home's procedure manual, for MediSystem, dated June 2020, included direction (s. 17.1.1) that nursing staff were responsible to discontinue medication on the Medication Administration Records.
Additionally, the procedures included direction when a resident was re-admitted from the hospital (s.12.1.11) which required staff to compare previous medication orders with those currently prescribed from the hospital. Staff were to note any discrepancies in the orders, prior to receipt of readmission orders and discrepancies were to be reported to the prescriber. When staff obtained the orders they were to note if each medication was to be continued, discontinued or put on hold based on the orders received.

i. A resident was readmitted to the home from the hospital.
A review of the Re-Admission Order Form, created two days prior to readmission, which was to be a listing of all orders prior to hospitalization included an order for a medication to be given as needed, an order not included on the resident's previous eMAR.
The medication was ordered to "continue" on the Re-Admission Order Form despite the fact that it was not a current order prior to hospitalization.
The Re-Admission Order Form did not included a signature of a second staff

member to indicate that they checked the orders as required.

ii. A resident was ordered a medication to be administered once a day.
A review of the Physician's Digiorder included a signature of the staff member who processed the order, without documentation that a second staff member completed a check of the order.
The order was processed accurately.

iii. A resident was readmitted from the hospital with orders for an intervention to be administered at a dose and the frequency of once a day and as needed.
According to the Physician's Digiorder the order was changed to a different dose and frequency.
According to the record the order was processed the day after it was received, by one nurse and checked two days after it was received, by a second staff member.
A review of the eMAR, after the change in direction was received, included both the original orders for the intervention as well as the revised orders.
The eMAR did not include that the original orders were crossed out or discontinued.
When staff processed and checked the orders they did not remove discontinued orders for the intervention.
The process was not followed which resulted in errors.

The orders were not processed according to the expectations as outlined which had the potential for error(s).

Sources: Review of the eMAR and physician's orders for a resident, review of procedures for Medication Management and interviews with staff. [s. 8. (1) (b)]

An order was made by taking the following factors into account:
Severity: The expectation of two staff to process physician's orders and medications being discontinued on the eMAR was not consistently followed which resulted in errors and omissions in documentation and the potential for medication errors.

Scope: This non-compliance was widespread, as it was identified in three

physician's orders reviewed.

Compliance History: Two voluntary plans of correction (VPCs) were issued to the home related to Ontario Regulation 79/10 s 8 (1), in the past 36 months.

(168)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Dec 11, 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 27th day of October, 2020**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** LISA VINK

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