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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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
Apr 06, 2021	2021_556168_0002 (A1)	024428-20, 000893-21	Complaint

Licensee/Titulaire de permis

Grace Villa Limited
284 Central Avenue London ON N6B 2C8

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

Grace Villa Nursing Home
45 Lockton Crescent Hamilton ON L8V 4V5

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

Amended by LISA VINK (168) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Amended non-compliance and rescinded compliance order (CO) for LTCHA s. 5 related to safe and secure home due to additional information provided to the inspector on March 29, 2021, which identified that Public Health directed the home that documentation related to the completion of twice a day monitoring in the clinical record was not required while the home was in outbreak as this information was recorded on the line listing.

Issued on this 6 th day of April, 2021 (A1)

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

Original report signed by the inspector.

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

Amended by LISA VINK (168) - (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): January 28, 2021, February 1, 2, 4, 5, 8, 9, 10, 11, 12, 17, 18, 2021 and March 8, 9 and 10, 2021, onsite and on February 16, 22, 23, 24, 25 and 26, 2021 and March 1, 2, 3, 4 and 5, 2021 off-site.

This inspection was completed with registered nursing student Olive Mameza Nenzeko in attendance.

Environmental Health Inspector, Bernadette Susnik, was consulted regarding this inspection.

This inspection was completed with concurrent Critical Incident System (CIS) inspection 2021_556168_0003.

This inspection was conducted for the following intakes:

024428-20 - related to bathing, medication administration, infection prevention and control and nutrition and hydration; and

000893-21 - related to infection prevention and control.

Please note:

Findings of non-compliance related to Long-Term Care Homes Act (LTCHA), 2007, chapter (c.) 8, section (s.) 6 (4) (a) and 6 (10) (b) both related to plan of care were identified in a concurrent CIS inspection, Inspection Report 2021_556168_0003, and were issued in this report.

Findings of non-compliance related to Ontario Regulation (O. Reg.) 79/10, s. 8 (1) b related to policies, etc. to be followed, 30. (1) 4 related to general requirements and 229 (5) related to infection prevention and control were identified in a concurrent CIS inspection, Inspection Report 2021_556168_0003, and were issued in this report.

This complaint inspection was conducted regarding concerns related to care and services provided to residents at the home during a COVID-19 outbreak.

The home reported in CIS report 2741-000017-21, a COVID-19 outbreak which was declared on November 25, 2020. The outbreak was declared over on January 9, 2021.

During the time of the outbreak the home was in frequent contact with Hamilton Public Health and site visits were conducted on November 27, 2020, December 11 and 16, 2020.

An onsite complaint inspection was conducted by a Ministry of Long-Term Care inspector, on December 15, 2020, with no findings of non-compliance identified.

On November 28, 2020, the home received an order under Section 29.2 of the Health Protection and Promotion Act, R.S.O. 1990, c. H. 7, from the associate Medical Officer of Health for the city of Hamilton, to include and accept Hamilton Health Sciences (HHS) and its designates in the monitoring, investigation and responding to their COVID-19 outbreak.

Subsequently, on December 16, 2020, the home entered into a voluntary management agreement with HHS.

During the course of the outbreak the home had staffing changes and implemented infection prevention and control measures which impacted routines and resident care.

Staff accounts identified that they prioritized tasks and care based on needs of the residents and that due to the changes and measures in place during the outbreak, the provision of care took longer to complete, there were delays in the care provided and changes in how some needs were met.

Staff identified that the provision of care and staffing levels in place at times during the outbreak varied based on their work location, shifts worked and that a number of staff worked overtime and back to back shifts to ensure the provision of care.

During the course of the inspection, the inspector(s) spoke with the Vice President (VP) of APANS, the Administrator, the former acting Director of Care (DOC), the current DOC, the former DOC, the assistant DOCs, Registered Nurses (RN), Registered Practical Nurses (RPN), pharmacy staff, Personal Support Workers (PSW), housekeeping staff, recreation and restorative staff, the Social Worker, the Physiotherapist (PT), staff from Hamilton Health Sciences, the Food Services Manager (FSM), Dietary Aids, APANS Nursing Consultant, Environmental Services Supervisor, COVID-19 screeners, a physician, laundry staff, family members and residents.

During the course of the inspection, the inspector observed the provision of care and services, toured the home, reviewed records including clinical health records, policies and procedures, risk management records, training records, complaint records and program evaluations.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
10 WN(s)
7 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 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 procedures included in the required Medication Management System were complied with.

In accordance with O. Reg. 79/10, s. 114 (1) the licensee was required to develop an interdisciplinary medication management system and in accordance with O. Reg. 79/10, s. 114 (2) the licensee was required to ensure that policies and protocols were developed for the accurate dispensing of all drugs used in the home.

A. Medisystem Pharmacy had a process in place to routinely provide medication delivery Monday through Friday to the home for most orders received prior to 1700 hours on business days when the orders were communicated to the pharmacy.

The home had an After Hours Pharmacy Procedure, which identified that if a new priority order was received after the cut off time for regular pharmacy delivery, staff were to transmit the order to Medisystem for processing and call the pharmacy, which depending on if the pharmacy was open or not they would be forwarded to the Emergency After Hours team. Additional direction was provided if staff were required to leave a message, the necessary information to include in their message and to call back if their request was not responded to in a timely manner. It was identified that the pharmacist would discuss and assess the order for priority and if necessary, make arrangements for delivery of the ordered medication(s).

According to the clinical record a resident was prescribed a medication on a Sunday.
The medication was not signed as administered until two days later.
There was no record that the staff attempted to receive the medication from the after hours team, when it was ordered on a Sunday and the pharmacy did not provide medication delivery on Sundays.
The medication was supplied by Medisystem Pharmacy during the next scheduled delivery.

There was a delay in the administration of the medication as ordered for the resident to treat symptom(s).

Sources: The Prescriber's Digiorder, electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) for a resident review of After Hours Pharmacy Procedure and interviews with staff.

B. The home had an emergency (stat) supply of medications which included identified medications for short term use in emergency situations when there would be a delay in receipt of the medication(s) from the pharmacy.

Medisystem Pharmacy procedure "Medications Used From The Facility's Emergency (Stat) Supply", directed staff to complete the emergency medication replacement form, fax the completed form to the pharmacy, record this action, store the completed form in a specific location to be retrieved when the medication was replaced and to complete documentation on receipt of replacement medication. Additionally, the procedure directed staff on the actions to be taken when narcotics were used from the emergency (stat) supply, the documentation required and actions required on the NACDAR (Emergency Narcotic and Controlled Drug Administration Record/Count Sheet).

A review of the Emergency Medication Audit and Reorder Form identified a number of missing or unaccounted for medications from the home's emergency (stat) supply. This audit was completed by the former acting DOC by counting and comparing the medications available in the emergency (stat) supply with the Emergency Drug Box List which was a list of the medications and quantities of each to be available.
Pharmacy staff who assisted in the investigation of some of the missing items and who completed a subsequent audit, identified inconsistencies in following the

procedures in the home related to the emergency (stat) supply, for record keeping.
A review of the records which were available in the home at the time of the inspection confirmed that staff did not consistently complete or process the required documentation needed according to the procedure when they took a medication from or when they received a medication for replacement for the emergency (stat) supply. The records provided to the inspector included that an Emergency Medication Replacement Form was used for multiple days, did not clearly indicate when the form(s) were faxed, did not consistently include if the replacement medication was received by the home and if so by which staff member, or follow up for any missing replacements with the pharmacy.

The procedures for emergency (stat) supply were not complied with which resulted in unaccounted for medications.

Sources: Medisystem Pharmacy procedures, review of emergency (stat) supply records and interviews staff. [s. 8. (1) (b)]

2. The licensee failed to ensure that a procedure included in the required Skin and Wound Care Program was complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 2 the licensee was required to have an interdisciplinary Skin and Wound Care Program and in accordance with O. Reg. 79/10, s. 30 (1) 1 the licensee was required to have written procedures for required programs.

The home's procedure, Nutrition and Skin Integrity, noted that the nursing staff would notify the dietary department of any resident who experienced skin breakdown, and that a dietary referral would be used to communicate this concern to the Registered Dietitian (RD).
Staff confirmed the expectation was that a referral was submitted to the dietary department when the area of skin breakdown was first identified.

i. A resident had a Head to Toe Skin Assessment completed which identified altered skin integrity.
According to the progress notes and the assessments a dietary referral was submitted five days after the areas were identified.
The RD assessed the resident's needs as a result of the referral the day the referral was received.

ii. A second resident had an area of altered skin integrity which was first assessed on a weekly wound assessment.
A dietary referral was not submitted until 13 days after the area of altered skin integrity was identified.
The resident had a second area of altered skin integrity identified.
The clinical record at the time of the inspection did not include a referral related to this area; however, the RD reviewed the nutritional status of the resident eight days later.

Submissions of dietary referrals is a communication strategy between the nursing and dietary departments.

Sources: Progress notes, assessments and referrals for residents and interviews with staff. [s. 8. (1) (b)]

3. The licensee failed to ensure that their procedure related to dealing with complaints was complied with.

In accordance with LTCHA, 2007 s. 21, the licensee was required to ensure that the long term care home had written procedures that complied with the regulations for initiating complaints to the licensee and for how the licensee dealt with complaints.

Specifically, staff did not comply with the licensee's Complaints Policy, C-7 which included a procedure that required all verbal complaints, about the operation of the home, be responded to immediately by the individual it was addressed to and that the complaint should be recorded on the Client Service Response Form.

Interview with a resident identified that they informed the Administrator of a concern.
The resident reported they were not aware of the outcome of this concern and that the Administrator had been "responsive" to their previous concerns.
The following month, the Administrator confirmed that the resident had reported a concern to them; however, that they had not followed up with the resident regarding the issue, nor initiated a Client Service Response Form.
Two days later a Client Service Response Form was initiated for the concern expressed the previous month.
The Administrator confirmed that they had met with the resident earlier that

morning regarding their plans to follow up with identified staff and at time the resident was satisfied at the conclusion of the conversation.
The concern was not responded to immediately as required.

The procedure was not followed to ensure that the concern was responded to immediately by the individual it was addressed to.

Sources: Review of Complaint Policy and Client Service Response Forms 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".

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 :

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

The home had an emergency (stat) supply of medications which included medications for short term use in emergency situations when there would be a delay in receipt of medications(s) from the pharmacy.
A review of the Emergency Drug Box List identified specific medications, including but not limited to antibiotics that were available in the home for immediate use by

residents, if prescribed.

A. According to the clinical record a resident was prescribed medications which were not administered as prescribed.
i. A review of the Prescriber's Digiorder identified that the resident was prescribed a medication to be applied twice a day.
The medication was both dispensed and received by the home two days later, following authorization for payment.
The eTAR included the treatment was to start the day that the medication was received.
Documentation on the eTAR included that the medication was "not available" on four occasions, although it had previously been received by the home.
There was a delay in the administration of the treatment as prescribed and the medication was not consistently administered as ordered.
ii. A review of the Prescriber's Digiorder identified that the resident was prescribed two medications, each for a duration of seven days.
The eMAR included a start date for one of the medications the day after it was ordered, and noted that the second medication was not available the day after it was prescribed and for this reason was started on day two after it was prescribed.
Staff did not obtain and administer the medications as prescribed by the physician, when they were available for use in the emergency (stat) supply, and there was a delay in the administration of the medications as prescribed.

B. According to the clinical record a second resident was prescribed medications which were not administered as prescribed.
A review of the Prescriber's Digiorder identified that the resident was prescribed two medications, orders indicated that the second medication was to be started if the resident was febrile.
The eMAR included that the first medication was administered the day after it was prescribed; however, was not available on one day, due to an insufficient supply sent by the pharmacy, in error.
The resident presented with a temperature the day after the medications were prescribed.
The eMAR included that the second medication was administered the day after the resident presented with a fever.
Staff did not administer the medications as prescribed by the physician, when they were available for use in the home in the emergency (stat) supply, there was a delay in the administration of the medications as prescribed and the medication was not consistently administered as ordered.

C. According to the clinical record a third resident was prescribed a medication which was not administered as prescribed.
A review of the Prescriber's Digiorder identified that the resident was prescribed a medication once a day for seven days.
According to the pharmacy packing slip the medication was delivered to the home the day after it was ordered.
The eMAR included that the medication was to be started the day it was delivered; however, was not signed as administered until the following day, two days after it was ordered.
The eMAR included that the medication was only signed as administered for six days and not the seven days as prescribed.
There was a delay in the administration of the medication as prescribed and according to the eMAR it was not administered for the duration of the order.

Sources: The Prescriber's Digiorder and eMAR and eTAR for the residents and interviews with staff. [s. 131. (2)]

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

Findings/Faits saillants :

(A1)
1. The licensee failed to ensure that the home was a safe environment related to the failure to maintain infection prevention and control measures specified in Directive #3 regarding the screening of residents twice a day for COVID-19

symptoms.

COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7, effective September 9, 2020, identified the requirement for homes to conduct active screening and assessment of all residents, including temperature checks, at least twice a day to identify if any resident had symptoms of COVID-19, and that those with symptoms were to be isolated and tested for COVID-19.

The home had developed a COVID-19 Resident Screening Tool which staff were to complete and record in point click care (PCC) twice a day for all residents. This tool directed staff to record resident temperatures, to monitor residents for common, other and atypical symptoms of COVID-19 as well as document their assessment results.

Registered nursing staff confirmed that it was the expectation that staff comply with the Directive and conduct the screening and assessments of residents twice a day and record this information in the clinical health record; however, some staff identified that they recorded temperature readings in the vital signs record in PCC, in addition to or rather than in the COVID-19 Resident Screening Tool.

Additional information provided identified that Public Health directed the home that documentation related to the completion of twice a day monitoring in the clinical record was not required while the home was in outbreak as this information was recorded on the line listing.

i. A review of the clinical record for a resident from mid November 2020, until mid February 2021, identified that not all COVID-19 Resident Screenings were recorded.
The resident was identified in their clinical record to be diagnosed with a virus. The resident did not consistently have a COVID-19 Resident Screening Tool documented at least twice a day on five occasions in February 2021. Additionally, there was no temperature reading documented at least twice a day on approximately five occasions in February 2021.

ii. A review of the clinical record for a second resident from mid November 2020, until mid February 2021, identified that not all COVID-19 Resident Screenings were recorded.

The resident was identified in their clinical record to be diagnosed with a virus. The resident did not have a COVID-19 Resident Screening Tool documented at least twice a day on one occasion in November 2020, prior to the declaration of the outbreak; and on six occasions in February 2021.

The screening of residents in long term care homes is a required practice in an effort to quickly identify possible cases of COVID-19 and implement interventions as appropriate to ensure safety.

Sources: A review of the COVID-19 Resident Screening Tools and vital signs records for residents and interviews with staff. [s. 5.]

Additional Required Actions:

(A1)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés: CO# 003

WN #4: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

According to the progress notes a resident, received a diagnosis and the physician ordered antibiotics. Subsequent progress notes identified that the resident had an infection.
A review of the Minimum Data Set (MDS) assessment completed after the diagnosis, under section I for disease diagnoses, noted that they did not present with any infections in 90 days prior.
The assessments were not integrated, consistent with and did not complement each other.

Sources: Clinical record for the resident including physician's orders, progress notes and interviews with staff. [s. 6. (4) (a)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A Head to Toe assessment of the resident was completed and included an area of altered skin integrity to a specific location.
Subsequent weekly wound assessments identified the area of altered skin integrity in another location.
The assessments were not consistent with and did not complement each other.

Sources: Head to Toe and weekly skin assessments of the resident and interviews with staff. [s. 6. (4) (a)]

3. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their responsive behaviour assessments were integrated, consistent with and complemented each other.

i. A review of the progress notes included that the resident demonstrated behaviours towards residents and staff on at least seven occasions in a month, and that on one of these occasions there was an injury.
The Resident Assessment Protocols (RAP) completed for mood state and behavioural symptoms related to the MDS assessment completed following the month, did not include the presence of the specific behaviour as a concern in the past 90 days.
ii. The resident had a Responsive Behaviour Assessment completed which identified that they had a history of responsive behaviours; and identified their current category of risk for co-residents.
A responsive behaviour displayed by the resident five days prior resulted in an injury to a co-resident.
Staff interviewed identified that the determination of risk to co-residents was based on the assessors clinical judgement; however, based on the review of the clinical record, in their opinions the risk level would have been different than the level noted on the completed assessment.

Assessment findings assist in the development and revision of the plan of care in an effort to ensure that resident care needs are met.

The assessments related to responsive behaviours were not integrated, consistent with and did not complement each other.

Sources: Clinical health record of the resident including progress notes and assessments and interviews with staff. [s. 6. (4) (a)]

4. The licensee failed to ensure that they documented the provision of the care, related to bathing, as set out in the plan of care.

i. According to the clinical record a resident was to be bathed three times a week, with specific dates identified.
Point of Care (POC) bathing records for 30 days identified that during this time period the resident received two bed baths and refused one bath.
There were no other bathing activities documented.
PSW staff indicated that during the identified time period they provided a bed bath to the resident when they worked on their scheduled bath days; however, did not document the provision of care due to time constraints.
Staff did not document the provision of care as set out in the plan related to bathing.

Sources: POC records and interviews with staff.

ii. Interview with a family member of a second resident reported that the resident was not consistently bathed twice a week as required during the outbreak.
According to the clinical record the resident was to be bathed twice a week, with specific dates identified.
POC bathing records for a 12 day period of time, identified that the resident was only provided one bed bath during the identified time period.
There was no other bathing activities documented.
PSW staff identified that they provided the resident a bed bath at the frequency of twice a week, during the time period of the outbreak; however, did not document this provision of care.

Sources: POC records and interviews with staff. [s. 6. (9) 1.]

5. The licensee failed to ensure that the plan of care for a resident was revised

when the resident's care needs changed.

According to the clinical record a resident sustained a fall.
The resident was assessed and was identified to have had a change in condition.
i. The PT assessed the resident and implemented specific fall prevention interventions.
A review of the care plan did not include the identified interventions for falls, under the falls focus statement, which still noted the use of a mobility device which was no longer current.
ii. Following the fall the resident had a change in status related to their activities of daily living and they required increased assistance with transfers.
The care plan included a goal to maintain the ability to be independent and safe during an activity with encouragement, reminders and supervision of one staff.
The goal and interventions were not reflective of the change in their care needs.

The plan of care was not updated with changes in care needs to provide direction to staff in the provision of care.

Sources: A review of the progress notes and plan of care for the resident and interviews with 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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other; that staff document the provision of the care as set out in the plan of care; and that the plan of care for resident are revised when the resident's care needs change, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

(A1)
1. The licensee failed to ensure that with respect to the falls prevention and management program they kept a written record which related to the evaluation which included the date of the annual evaluation of the program, the names of the persons who participated, a summary of the changes made and the date that those changes were implemented.

O. Reg. 79/10 s. 48 (1) 1 required each long-term care home to have an interdisciplinary program developed and implemented for a falls prevention and management program.

A review of the Quality Management Audit Report - Annual Evaluation - Falls Prevention Program was completed.
According to the document, which was an audit, staff and family members were interviewed to identify their awareness of the program; however, there was not a written record of an evaluation and a summary of the changes made to the program, who participated and the dates when the changes were implemented.
The Administrator identified that there was an ongoing process of assessing and evaluating programs; however, this was not consistently documented as required.

An evaluation of programs assists to ensure that it meets the needs of the residents of the home.

Sources: Quality Management Audit Report - Annual Evaluation - Falls Prevention Program, and interview with staff. [s. 30. (1) 4.]

2. The licensee failed to ensure that any actions taken with respect to residents under LTCHA, s. 11 (1) which required homes to ensure that there was an organized program of nutritional care and hydration to meet the needs of residents, that the program, including interventions and the resident's responses to interventions were documented.

The home's program to monitor the food and fluid intake of residents with identified risks related to nutrition and hydration included documentation of intake in POC records.
Interviews with staff were conflicting related to if beverages and snacks were offered outside of meal times, during the outbreak, and a number of staff reported that the staffing levels and changes in resident care requirements resulted in delayed meals and challenges in meeting resident care needs during meal times.
Registered staff identified that fluids provided by other interventions were not recorded in POC records, but in the eMAR and progress notes.
The intervention to provide additional fluids was not consistent as to the quantity received by the residents.

i. According to the clinical record a resident was assessed by the RD. They were

noted to be at risk due to nutritional factors and were prescribed a nutritional supplement with suggestions for additional hydration.
A review of the POC, progress notes and eMAR records for a 16 day period of time identified that not all interventions were documented.
The POC records did not include documentation for the amount of fluid they consumed or the percentage of a meal they ate on four occasions during the identified time period.
Additionally, the POC records were blank for their between meal beverages in the morning, afternoon or evening on 26 occasions in total, during the identified time period.
The resident was ordered an intervention to increase fluids on two occasions, as noted on the eMAR.
The record noted that the intervention was initiated to increase fluids; however, the documentation of the volume of fluid received was not clear when the intervention was in place.
Progress notes identified that the intervention was implemented a second time; however, was later discontinued.
The record, including the POC records, eMAR and progress notes did not clearly identify the volume of fluid received during the intervention.

ii. According to the clinical record a second resident was at nutritional risk based on an assessment completed by the RD.
A review of the POC records for a 30 day time period and a review of progress notes and eMAR records for a 13 day period of time, identified that not all interventions were documented.
The POC records did not include documentation for the amount of fluid they consumed or the percentage of a meal they ate on two occasions during the identified time period.
Additionally, the POC records were blank for their between meal beverages in the morning, afternoon or evening on 42 occasions in total, during the identified time period.
The resident had an intervention in place on two occasions, as noted on the eMAR.
The record noted that the intervention to increase fluids was initiated and continued for three days.
The records did not include a specific volume of fluid received when the intervention was in place.
The intervention was prescribed a second time and continued for approximately six days.

The record, including the POC records, eMAR and progress notes did not clearly identify the volume of fluid received during the intervention.

iii. According to the clinical record a third resident was identified at nutritional risk based on an assessment.
A review of the POC records for the time period of one month identified that not all interventions were documented.
The POC records did not include documentation for the amount of fluid they consumed or the percentage of a meal they ate on 11 occasions during the identified time period.
Additionally, the POC records were blank for their between meal beverages in the morning, afternoon or evening on 43 occasions in total, during the identified time period.

Intake records are used to evaluate whether a residents intake is meeting their assessed needs and if further intervention is required.

Sources: Progress notes, eMAR and POC records for residents and interviews with staff. [s. 30. (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 with respect to the falls prevention and management program they keep a written record which related to the evaluation which includes the date of the evaluation, the names of the persons who participate, a summary of the changes made and the date that those changes are implemented; and that any actions taken with respect to resident under a program includes documentation of the interventions and the residents response, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident was bathed, at a minimum, twice a week, unless contraindicated by a medical condition.

Public Health declared the home in an outbreak, which required residents to be isolated in their rooms.
Interview with a resident identified that they were not bathed twice a week for a period of time during the outbreak.
POC bathing records for a 30 day time period identified that they were not bathed as scheduled on eight occasions.

Sources: Interview with and POC records for the resident and interviews with staff. [s. 33. (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 residents are bathed at a minimum, twice a week, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who exhibited altered skin integrity were reassessed at least weekly by a member of the registered nursing staff.

i. A resident presented with an area of altered skin integrity.
A review of the documented assessments identified that the area was not consistently reassessed weekly.
The area had a documented assessment completed; however, was not reassessed again until 14 days later. Progress notes documented between the two assessments supported that staff were monitoring and assessing the area of altered skin integrity; however, the full assessments were not recorded.
The area was reassessed again in 2021; however, following this reassessment it was not assessed again until 11 days later, according to the documentation.
It was noted that the area had decreased in size during the time frame reviewed.

ii. According to weekly wound assessments a second resident had two areas of altered skin integrity.
A review of weekly wound assessments identified that the areas did not consistently have documented reassessments recorded on a weekly basis.
The first area had a documented assessment included in the clinical record; however, the area was not reassessed for another 14 days.
The second area had a documented assessment recorded in the clinical record; however, a reassessment was not completed until 14 days later.
According to the assessments conducted the area was improving.

Weekly assessments of areas of altered skin integrity assist in evaluating the effectiveness of the interventions in the plan of care.

Sources: Progress notes and weekly wound assessments for residents and interviews with staff. [s. 50. (2) (b) (iv)]

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 residents with altered skin integrity are reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(a) is a minimum of 21 days in duration; O. Reg. 79/10, s. 71 (1).
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).
(d) includes alternative beverage choices at meals and snacks; O. Reg. 79/10, s. 71 (1).
(e) is approved by a registered dietitian who is a member of the staff of the home; O. Reg. 79/10, s. 71 (1).
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).
(g) is reviewed and updated at least annually. O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's menu cycle was a minimum of 21 days in duration and included alternative choices of vegetables at lunch and dinner.

The home implemented an emergency menu during their outbreak.
The menu was implemented sometime during the first week of December 2020, until approximately the last week of January 2021.
The FSM identified that the menu was provided by their corporate provider, approved by their RD and was less labour intensive for staff and included easier to make menu items. It was identified that there were no changes to the snack menu during this time period.

The Emergency Menu 20/21 was reviewed and it was 14 days in duration and included a hot entrée and a sandwich at lunch and dinner. There were no alternative choices of vegetables at either meal.
The menu was not 21 days in duration and did not include an alternative choice of vegetables at lunch and dinner.

Interview with a resident identified that they were not offered a choice at meals times during the outbreak and were frequently served a sandwich.

Sources: Review of Emergency Menu 20/21 and interviews with staff. [s. 71. (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 the home's menu cycle is a minimum of 21 days in duration and includes alternative choices of vegetables at lunch and dinner, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The home changed pharmacy service providers in the fall of 2020.
The most recent Professional Advisory Committee (PAC) meeting was held in July 2020, with the pharmacist in attendance.
The Pharmacy Report which was included in the meeting minutes noted that the annual evaluation of the medication management system was outstanding for 2020, and a date for the review was to be determined.
It was confirmed that the home was not able to conduct an interdisciplinary evaluation of the effectiveness of the medication management system in 2020; however, that a Quality Management Audit Report - Medication Administration System Audit and Evaluation was completed in 2021, which involved interviews of registered staff regarding awareness of the medication administration procedures.

An evaluation of the effectiveness of the medication management system assists in recommending changes to improve the system.

Sources: PAC meeting minutes, Quality Management Audit Report - Medication Administration System Audit and Evaluation and interview with staff. [s. 116. (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 an interdisciplinary team meet annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that the Infection Prevention and Control (IPAC)

interdisciplinary team met at least quarterly in 2020.

The home's IPAC team met as part of the PAC with meetings scheduled to be completed on a quarterly basis.
In 2020, the home had PAC/IPAC meetings on two dates only due to the cancellation of other scheduled meetings.

The IPAC interdisciplinary team did not meet quarterly in 2020 to discuss and review issues and events related to infection prevention and control.

Sources: PAC meeting minutes and interview with staff. [s. 229. (2) (b)]

2. The licensee failed to ensure that the IPAC program was evaluated and updated annually in accordance with evidence-based practices (EBPs), specifically related to enhanced cleaning and disinfection measures during an outbreak.

The EBP document entitled “Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd edition, had been established as a best practice for cleaning and disinfection along with other best practice documents from Public Health Ontario.

The home reported an outbreak which was declared in 2020 and was finalized in 2021.
It was reported that in early 2020, the home implemented an additional staff position to complete high touch surface cleaning daily.
Prior to the outbreak five housekeeping staff were scheduled to work daily, in addition to the staff responsible for high touch cleaning surface cleaning staff.
During the outbreak due to the care needs of residents and staffing needs there was a reassignment of staff roles and duties, which impacted a number of staff and departments.

The licensee provided their outbreak cleaning and disinfection policies and procedures, one that was dated 2017, and two that did not include a date but were reported to have been acquired in March 2020. Staff could not confirm the date that the March 2020, procedures were fully implemented or whether these new procedures were evaluated to determine if they were developed in accordance with EBPs.

Procedures titled Isolation Cleaning Procedures and Cleaning During Outbreak Conditions were reviewed along with procedures from 2017, which included Outbreak Cleaning.

The Outbreak Cleaning procedure included information that the housekeeping staff would work in conjunction with nursing services at the time of any outbreak to initiate extra cleaning/disinfecting/carbolizing routines as may be directed by the Infection Control Nurse Manager. No additional guidance was included regarding this process. It also included direction for staff to wipe daily with approved disinfectant all contact areas such as handrails, the area around door knobs, toilets and counters and other cleaning as recommended by Public Health. No details were provided about the disinfectant and no direction was included about the cleaning and disinfection process for residents on additional precautions. The procedure also included that the cleaning and disinfecting area is regularly and adequately cleaned and no other details.

The Isolation Cleaning Procedures included specific cleaning and disinfecting tasks for residents who were on transmission based precautions, but no direction regarding how cleaning tasks would be different for respiratory versus enteric outbreak situations.
The procedure Cleaning During Outbreak Conditions was missing specific details about what changes would be made to environmental services hours to support enhanced cleaning and disinfection, how the mode of transmission would impact cleaning routines and what specific disinfectants were suitable for use during an outbreak.
According to the EBP noted above, procedures must include sufficient staffing and resources to allow for the provision of additional environmental cleaning capacity during outbreaks that does not compromise routine cleaning of any resident rooms, that allows for more intensive and frequent cleaning (and monitoring of cleaning) and cleaning and disinfection standards.

COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007 Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7, directed to all long-term care homes on October 16, 2020, that additional environmental cleaning was recommended for frequently touched surfaces, and that consideration be given to increasing the frequency of cleaning and that policies and procedures should allow for surge capacity including additional staff, supervision, supplies and cleaning. A link was included in the Directive to the above noted EBP for further guidance.

The long-term care home's IPAC program, which is required to include measures to control an outbreak (cleaning and disinfection) were not updated in accordance with the above referenced EBP or the Chief Medical Officer's Directive #3.

Policies and procedures are to be reflective of EBP to ensure appropriate direction to staff.

Sources: Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd edition, policies and procedures provided by the home related to environmental cleaning and outbreak control and interviews with staff. [s. 229. (2) (d)]

3. The licensee failed to ensure that on every shift, symptoms which indicated the presence of infection in residents were monitored in accordance with evidence-based practices and, if there was none, in accordance with prevailing practices; and the symptoms were recorded and that immediate action was taken as required.

A. Progress notes for a resident identified that they presented with symptoms. The clinical record did not include additional assessments or monitoring of the resident on the following shift.
Registered staff who worked on the following shift reported that the resident would have been monitored due to the symptoms presented earlier, but this action was not recorded.

B. A review of the clinical record for another resident identified that not all monitoring activities of the resident were recorded.
i. The COVID-19 Resident Screening Tool completed on a date in December 2020, identified that the resident presented with a least one of 10 identified atypical symptoms of COVID-19 and they were on precautions effective immediately.
The record did not specify which symptom(s) the resident experienced.
A progress note completed a few days later identified that the resident presented with specific symptoms on the date that the COVID-19 Resident Screening Tool was completed; however, the symptoms had since subsided.
The resident was subsequently tested and diagnosed with a virus.
ii. A review of the clinical record noted that the resident was diagnosed with a virus. According to the clinical record the resident did not have their symptoms

consistently monitored or documented every shift over the next six days.

C. A review of the clinical record for a third resident identified that not all monitoring activities to indicate the presence of infection were recorded.
The clinical record did not include documentation that the resident, who demonstrated symptoms and was diagnosed with a virus two days later, consistently had their symptoms monitored every shift to indicate the presence of infection from the time that they presented with symptoms and over the next 10 days.

D. A review of the clinical record for a fourth resident identified that not all monitoring activities of the resident were documented.
The clinical record did not include documentation that the resident, who was diagnosed with a virus, had their symptoms consistently monitored every shift to indicate the presence of infection over a five day period of time.

The monitoring of residents is a required practice in an effort to quickly identify possible infections and implement interventions as appropriate to ensure safety.

Sources: A review of the progress notes for the residents and interviews with staff. [s. 229. (5)]

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 Infection Prevention and Control (IPAC) interdisciplinary team meet at least quarterly, to ensure that the IPAC program is evaluated and updated annually in accordance with evidence-based practices (EBPs) and that on every shift, symptoms which indicate the presence of infection are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and the symptoms are recorded and that immediate action is taken as required, to be implemented voluntarily.

Issued on this 6 th day of April, 2021 (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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by LISA VINK (168) - (A1)
Inspection No. / No de l'inspection :	2021_556168_0002 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	024428-20, 000893-21 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 06, 2021(A1)
Licensee / Titulaire de permis :	Grace Villa Limited 284 Central Avenue, London, ON, N6B-2C8
LTC Home / Foyer de SLD :	Grace Villa Nursing Home 45 Lockton Crescent, Hamilton, ON, L8V-4V5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janette West

To Grace Villa 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 :

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 section 8 (1) of Ontario Regulation 79/10.

Specifically the licensee shall:
a. provide information and education to all registered nursing staff on the use of the emergency pharmacy including how and when to access this service;
b. provide information to all registered nursing staff on the specific medications and their dosages which are maintained in the emergency (stat) supply;
c. provide education on the procedures related to the emergency (stat) supply of medications to all registered staff including who may access the supply, when it is to be accessed and all required documentation to be completed;
d. ongoing auditing of the emergency (stat) supply by DOC or designate, in addition to the quarterly pharmacy audits, at a frequency as determined by the home until staff are compliant with the procedures for removing and replacing the medications, when prescribed; and
e. post the information as required in items a and b above in each medication room in a prominent location for staff reference.

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

Grounds / Motifs :

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

In accordance with O. Reg. 79/10, s. 114 (1) the licensee was required to develop an interdisciplinary medication management system and in accordance with O. Reg. 79/10, s. 114 (2) the licensee was required to ensure that policies and protocols were developed for the accurate dispensing of all drugs used in the home.

A. Medisystem Pharmacy had a process in place to routinely provide medication delivery Monday through Friday to the home for most orders received prior to 1700 hours on business days when the orders were communicated to the pharmacy.

The home had an After Hours Pharmacy Procedure, which identified that if a new priority order was received after the cut off time for regular pharmacy delivery, staff were to transmit the order to Medisystem for processing and call the pharmacy, which depending on if the pharmacy was open or not they would be forwarded to the Emergency After Hours team. Additional direction was provided if staff were required to leave a message, the necessary information to include in their message and to call back if their request was not responded to in a timely manner. It was identified that the pharmacist would discuss and assess the order for priority and if necessary, make arrangements for delivery of the ordered medication(s).

According to the clinical record a resident was prescribed a medication on a Sunday.
The medication was not signed as administered until two days later.
There was no record that the staff attempted to receive the medication from the after hours team, when it was ordered on a Sunday and the pharmacy did not provide medication delivery on Sundays.
The medication was supplied by Medisystem Pharmacy during the next scheduled delivery.

There was a delay in the administration of the medication as ordered for the resident to treat symptom(s).

Sources: The Prescriber's Digiorder, electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) for a resident review of After Hours Pharmacy Procedure and interviews with staff.

B. The home had an emergency (stat) supply of medications which included identified medications for short term use in emergency situations when there would be a delay in receipt of the medication(s) from the pharmacy.

Medisystem Pharmacy procedure "Medications Used From The Facility's Emergency (Stat) Supply", directed staff to complete the emergency medication replacement form, fax the completed form to the pharmacy, record this action, store the completed form in a specific location to be retrieved when the medication was replaced and to complete documentation on receipt of replacement medication. Additionally, the procedure directed staff on the actions to be taken when narcotics were used from the emergency (stat) supply, the documentation required and actions required on the NACDAR (Emergency Narcotic and Controlled Drug Administration Record/Count Sheet).

A review of the Emergency Medication Audit and Reorder Form identified a number of missing or unaccounted for medications from the home's emergency (stat) supply. This audit was completed by the former acting DOC by counting and comparing the medications available in the emergency (stat) supply with the Emergency Drug Box List which was a list of the medications and quantities of each to be available. Pharmacy staff who assisted in the investigation of some of the missing items and who completed a subsequent audit, identified inconsistencies in following the procedures in the home related to the emergency (stat) supply, for record keeping. A review of the records which were available in the home at the time of the inspection confirmed that staff did not consistently complete or process the required documentation needed according to the procedure when they took a medication from or when they received a medication for replacement for the emergency (stat) supply. The records provided to the inspector included that an Emergency Medication Replacement Form was used for multiple days, did not clearly indicate when the form (s) were faxed, did not consistently include if the replacement medication was received by the home and if so by which staff member, or follow up for any missing replacements with the pharmacy.

The procedures for emergency (stat) supply were not complied with which resulted in unaccounted for medications.

Sources: Medisystem Pharmacy procedures, review of emergency (stat) supply

records and interviews staff. [s. 8. (1) (b)]

An order was made by taking the following factors into account:
Severity: This non-compliance had the potential to negatively impact residents as some of the medications which were unaccounted for from the emergency (stat) supply or emergency pharmacy were prescribed to treat acute conditions.
Scope: The scope of this non-compliance was identified to be patterned due to the frequency that the identified procedures related to pharmacy services were not complied with.
Compliance History: This subsection was issued as a voluntary plan of correction (VPC) on April 23, 2018, during inspection 2018_587129_0003; as a written notification (WN) on April 25, 2019, during inspection 2019_689586_0004; and as a compliance order (CO) on December 23, 2019, during inspection 2019_689586_0026 and was complied on March 11, 2020. (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 12, 2021

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 shall be compliant with section 131 (2) of Ontario Regulation 79/10.

Specifically the licensee shall ensure that residents are administered drugs in accordance with the directions for use as specified by the prescriber.

The licensee shall ensure that:
a. there is a written record of the administration of all drugs in the clinical record;
b. if a drug is not administered as prescribed there is a process in place which is communicated to all registered nursing staff to document in the clinical record why the medication was not given as prescribed; and
c. that drugs are obtained from the emergency (stat) supply, when not available in a timely fashion from the pharmacy, if prescribed and based on the resident's needs.

Grounds / Motifs :

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

The home had an emergency (stat) supply of medications which included medications for short term use in emergency situations when there would be a delay in receipt of medications(s) from the pharmacy.
A review of the Emergency Drug Box List identified specific medications, including but not limited to antibiotics that were available in the home for immediate use by

residents, if prescribed.

A. According to the clinical record a resident was prescribed medications which were not administered as prescribed.
i. A review of the Prescriber's Digiorder identified that the resident was prescribed a medication to be applied twice a day.
The medication was both dispensed and received by the home two days later, following authorization for payment.
The eTAR included the treatment was to start the day that the medication was received.
Documentation on the eTAR included that the medication was "not available" on four occasions, although it had previously been received by the home.
There was a delay in the administration of the treatment as prescribed and the medication was not consistently administered as ordered.
ii. A review of the Prescriber's Digiorder identified that the resident was prescribed two medications, each for a duration of seven days.
The eMAR included a start date for one of the medications the day after it was ordered, and noted that the second medication was not available the day after it was prescribed and for this reason was started on day two after it was prescribed.
Staff did not obtain and administer the medications as prescribed by the physician, when they were available for use in the emergency (stat) supply, and there was a delay in the administration of the medications as prescribed.

B. According to the clinical record a second resident was prescribed medications which were not administered as prescribed.
A review of the Prescriber's Digiorder identified that the resident was prescribed two medications, orders indicated that the second medication was to be started if the resident was febrile.
The eMAR included that the first medication was administered the day after it was prescribed; however, was not available on one day, due to an insufficient supply sent by the pharmacy, in error.
The resident presented with a temperature the day after the medications were prescribed.
The eMAR included that the second medication was administered the day after the resident presented with a fever.
Staff did not administer the medications as prescribed by the physician, when they were available for use in the home in the emergency (stat) supply, there was a delay

in the administration of the medications as prescribed and the medication was not consistently administered as ordered.

C. According to the clinical record a third resident was prescribed a medication which was not administered as prescribed.
A review of the Prescriber's Digiorder identified that the resident was prescribed a medication once a day for seven days.
According to the pharmacy packing slip the medication was delivered to the home the day after it was ordered.
The eMAR included that the medication was to be started the day it was delivered; however, was not signed as administered until the following day, two days after it was ordered.
The eMAR included that the medication was only signed as administered for six days and not the seven days as prescribed.
There was a delay in the administration of the medication as prescribed and according to the eMAR it was not administered for the duration of the order.

Sources: The Prescriber's Digiorder and eMAR and eTAR for the residents and interviews with staff. [s. 131. (2)]

An order was made by taking the following factors into account:
Severity: This non-compliance had the potential to negatively impact each of the residents identified.
Scope: The scope of this non-compliance was widespread as it was identified in three of three resident records reviewed.
Compliance History: This subsection was issued as a compliance order (CO) on April 23, 2018, during inspection 2018_587129_0003, and was complied on April 17, 2019. (168)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 09, 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

(A1)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 003

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

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

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

Order(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

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:

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

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

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

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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
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 6 th day of April, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by LISA VINK (168) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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