



**Ministry of Health and
Long-Term Care**

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

**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de
longue durée
Inspection de soins de longue durée**

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de
Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 21, 2017	2017_378116_0018	026126-17	Critical Incident System

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

Midland Gardens Care Community
130 MIDLAND AVENUE SCARBOROUGH ON M1N 4B2

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

SARAN DANIEL-DODD (116)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 17, 20, 21, 22, 23, 27, 28, 29, 2017.

This inspection was conducted concurrently with inspection #2017_378116_0019 related to medication misappropriation.

During the course of the inspection, the inspector(s) spoke with the Executive Director (E.D.), Directors of Care (DOC), representative(s) of an identified pharmacy, registered staff (RN) (RPN), personal support worker's (PSW) and residents.

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

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

- 2 WN(s)**
- 1 VPC(s)**
- 1 CO(s)**
- 0 DR(s)**
- 0 WAO(s)**



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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).	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 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 has failed to ensure that 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.

On an identified date, the licensee submitted a critical incident system report to the Director reporting a medication incident with a possible adverse drug reaction. The CIS read as follows:

Resident #001 obtained a package of nearly delivered medication and consumed them. The resident was transferred to the hospital and returned to the home.

The identified medication is classified as a controlled substance.

Review of the homes internal investigation and progress notes for resident #001 indicated that the resident obtained possession of the controlled substances after medications were delivered to the unit on behalf of the homes pharmacy during an identified shift.

The homes process for acceptance/delivery of medications is for a member of the receiver (the home) to sign and date the delivery manifest upon acceptance of medications. Review of the medication delivery manifest indicated that items were delivered to two identified units; there was no signature or date acknowledging the



acceptance of medication items on the homes behalf for the delivery on the specified date.

Interviews held with registered staff member #'s 104, #105, #108 and the delivery representative of the identified pharmacy provided conflicting information of the actual events that occurred. Registered staff member #'s 104, #105, #108 and the delivery representative indicated having knowledge on the process for delivering and accepting medications at the home. The delivery representative indicated that upon arrival to the unit the registered staff members were pre-occupied however, the delivery representative stated that registered staff member #105 was aware that the bag containing medications was left at the nursing station. Registered staff members #'s 104, #105 and #108 denied they had knowledge of the medication bag being delivered to the unit.

An interview with resident #001 indicated that he/she removed the medication package and was aware that the medications were not prescribed to him/her and the potential risks in consuming the identified medications.

Upon initiation of the inspection the following observations were noted on specified dates:

On an identified date, inspector #116 reviewed the medication cart stored in the hallway which was assigned to registered staff member #106 in the presence of DOC #002. Inspector #116 discovered half of an unlabelled pill stored in the top drawer of the medication cart. An interview held with registered staff #106 confirmed that the identified pill was prescribed to resident #002 and classified as a controlled substance and acknowledged that it is to be kept in a separate locked area within the locked medication cart.

Interviews held with the DOC's confirmed that the controlled substances were not stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart on the identified unit.

The severity of harm is actual harm due to resident #001 consuming the identified controlled substances, the scope is isolated and the home does not have a compliance history with this legislation. [s. 129. (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. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
 - i. persons who may dispense, prescribe or administer drugs in the home, and
 - ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

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

On an identified date, the medication cart assigned to a specified unit was noted to be stored in the hallway unlocked and unsupervised. Residents and other staff members were noted in the hallway. Registered staff member #107 who was assigned to the medication cart was noted to be in the hallway assisting a resident. Inspector #116 was able to gain access to the cart prior to the staff member being aware that the medication cart was accessed. Registered staff member #107 came over and attended to the cart and acknowledged being aware that the cart is to be locked at all times when unsupervised.

Further interviews held with DOC #002 confirmed that all areas where drugs are stored are to be kept locked at all times when not in use. [s. 130. 1.]



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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 has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

Issued on this 11th day of January, 2018

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

Original report signed by the inspector.



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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 Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée
Inspection de soins de longue durée**

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : SARAN DANIEL-DODD (116)

Inspection No. /

No de l'inspection : 2017_378116_0018

Log No. /

No de registre : 026126-17

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Dec 21, 2017

Licensee /

Titulaire de permis : 2063414 ONTARIO LIMITED AS GENERAL PARTNER
OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200, TORONTO, ON,
L3R-0E8

LTC Home /

Foyer de SLD : Midland Gardens Care Community
130 MIDLAND AVENUE, SCARBOROUGH, ON,
M1N-4B2

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Debbie Fleming



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Pursuant to section 153 and/or
section 154 of the *Long-Term Care
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To 2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414
INVESTMENT LP, you are hereby required to comply with the following order(s) by
the date(s) set out below:

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

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Order # /

Ordre no : 001

Order Type /

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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

(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).

Order / Ordre :

Upon receipt of this compliance order the licensee shall prepare, submit and implement a plan to ensure that:

- 1) Provide education and/ or retraining to all registered staff on the licensee's procedure for delivery of medications and Controlled Substances.
- 2) The training should identify the process of acceptance of controlled substances
- 3) Develop and implement a process to ensure that only registered staff members and required designates are able to gain access to the contents of medication carts, specifically controlled substances.

Please submit the plan to Saran.DanielDodd@ontario.ca. on or before January 12, 2018 .

Grounds / Motifs :

1. The licensee has failed to ensure that 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.



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The severity of harm is actual harm due to resident #001 consuming the identified controlled substances, the scope is isolated and the home does not have a compliance history with this legislation. [s. 129. (1) (b)]

(116)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Feb 02, 2018



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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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



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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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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.



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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 de la Santé et des Soins de longue durée
1075, rue Bay, 11^e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603



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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 21st day of December, 2017

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



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Name of Inspector /

SARAN Daniel-Dodd

Nom de l'inspecteur :

Service Area Office /

Bureau régional de services : Toronto Service Area Office