Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

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

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 10, 2021	2021_876606_0011	022152-20, 000628-21, 004502-21, 005838-21	Critical Incident System

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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

Midland Gardens Care Community
130 Midland Avenue Scarborough ON M1N 4E6

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

JANET GROUX (606), DANIELA LUPU (758)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 28-30, and May 3-7, 2021.

The following intakes were completed in this critical incident system (CIS) inspection:
Log #000628-21 related to a resident to resident altercation;
Log #004502-21, related to a resident's fall;
Log #005838-21, and Log #005838-21, related to resident abuse; and
Log #022152-20, follow-up to Compliance Order (CO) #001 from inspection #2020_767643_0020 regarding r. 8. (1) with a Compliance Due Date (CDD) March 5, 2021.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Infection Prevention and Control (IPAC) Lead, Physiotherapist (PT)/Falls Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspectors observed resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care related to falls prevention was provided to residents #001 and #003 as specified in the plan of care.

A) A Critical Incident (CI) submitted to the Ministry of Long-Term Care (MLTC) reported resident #001 fell and sustained an injury.

Resident #001 was at risk for falls. Their plan of care directed the staff to ensure resident #001 used a specific falls prevention device at all times. During an observation, resident #001 was not using the specified falls prevention device as stated in their plan of care. This was acknowledged by a Registered Nurse (RN).

Failing to ensure that the plan of care related to a specified falls prevention device was implemented as outlined in the plan of care resulted in actual harm to resident #001.

Sources: A CI report, observations of resident #001, resident #001's clinical records and interviews with staff.

B) Resident #003 was at at risk for falls. Their plan of care directed staff to ensure that a specified falls prevention equipment was applied in their room and that resident #003 used a particular falls prevention device when they were in bed.

During an observation, resident #003 did not have the specified falls interventions in place as specified in resident #003's plan of care.

Failing to ensure that falls prevention measures were implemented for resident #003 as per their plan of care put the resident at further risk for falls injuries.

Sources: resident #003's clinical records, an observation of resident #003, and interviews with staff.

2. The licensee has failed to ensure that when a resident had a change in their condition, their plan of care was reviewed and revised.

Resident #001 was at risk for falls related to their medical conditions.

In 2021, resident #001 had a number of falls on identified dates without injury. They were reassessed to have specific risk factors that could cause them to fall. The assessments stated the resident would need one person for care, and for staff to ensure they implemented a couple of specific falls prevention interventions. However, review of resident #001’s plan of care was not updated as required to include the recommended falls prevention interventions until an identified date.

On an identified date, resident #001 was transferred to the hospital after they fell and was diagnosed with a serious injury. Upon readmission, resident #001 was reassessed and was identified with a change in their condition. A specific intervention was implemented on an identified date to manage the resident's fall risk but was not included in the resident’s plan of care as required.

During a number of observations, staff initiated a number of falls interventions for resident #001. However, the falls interventions applied by staff were inconsistent during each observation. A review of the resident’s plan of care showed the falls interventions observed were not included in the resident’s plan of care. The Falls Lead acknowledged that the resident’s plan of care should have been reviewed and updated after they had a change in their condition to include the recommended falls interventions.

Failing to ensure that a resident’s plan of care was reviewed and revised in terms of their falls management could have put the resident at further risk of falls and injuries.

Sources: observations of resident #001, review of their clinical records, and interviews staff and the Falls Lead.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident is reassessed, the plan of care is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: 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 :

The licensee has failed to ensure that the Home's "Medication Pass" policy was complied with for residents #006, #007, #013, #015, #016, #017 and #018.

As required by the Ontario Regulation 79/10, s. 114 (2) the licensee was to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The Home's "The Medication Pass" policy required the registered staff to administer a medication by following the rights to medications administration and included the right resident, medication, dosage, route, reason, time, and documentation.

Resident #006, #007, #013, #015, #016, #017 and #018's medication audits from Point

Click Care (PCC) for identified dates showed a number of medications that were scheduled at specified times were administered late.

The medication audit showed a number of registered staff members failed to follow the Home's medication pass policy.

The Director of Care (DOC) acknowledged medications could be given one hour prior to or one hour after the scheduled administration time.

RPN #119 said they administered resident #006, #016, #017, and #018's medications on time but forgot to document in the electronic Medication Administration Records (e-MARs) until later.

RPN #123 acknowledged they were not able to administer resident's #013, #017, and #018's on time because the residents refused the medications or the resident were asleep.

RPN #119 and #123 acknowledged that they did not follow the Home's medication administration policy.

Failure to follow the Home's medication pass policy could cause the residents to have adverse effects related to their medications and put their health condition at further risk of harm.

Sources: The Home's "The Medication Pass" policy, Resident #006, #007, #013, #015, #016, #017 and #018 medication audits in PCC, and staff interviews.

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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure resident #017 was protected from physical abuse by resident #003.

Section 2 (1) of the Ontario Regulation 79/10 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

A critical incident (CI) submitted to the Ministry of Long Term Care (MLTC) reported resident #017 sustained an injury after an altercation with resident #003.

Resident #022 said they witnessed the altercation between residents #003 and #017.

RPN #121 said resident #017 sustained an injury as a result of an altercation with resident #003.

Failing to protect resident #017 from abuse by resident #003 caused minimal harm to resident #017 as they sustained an injury.

Sources: A CI report, resident #003 and #017's clinical records, and an interview with a resident and staff. [s. 19. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The licensee has failed to ensure the Home's policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy titled "Prevention of Abuse and Neglect of a resident stated that upon receiving the notification of an alleged, suspected or actual abuse of a resident the Executive Director (ED) or designate will immediately determine if the team member should be sent home and communicate to them that they would be sent home pending investigation of the incident.

An RPN reported to the Director of Care (DOC) and Associate Director of Care (ADOC) that a resident alleged abuse by a PSW. The PSW continued to work in the Home and provided care to the resident as well as other residents after the alleged abuse incident was reported.

Failure to immediately remove the PSW from the Home after an allegation of abuse against them could have potentially put residents at risk of harm by the PSW as they continued to provide care to residents after the allegation of abuse was reported against them.

Sources: A CI report, the home's investigative notes, a resident’s progress notes, the home's prevention of abuse and neglect policy, and interviews with a PSW, ADOC and DOC.

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 a written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that an allegation of resident abuse was immediately reported to the Director.

A resident reported to an RPN that a PSW abused them during care. The RPN reported the incident to the ADOC immediately, and the DOC was also notified in the same day. However, the incident was not reported to the Director until the following day.

Sources: A CI report, the home's investigative notes, a resident's progress notes and interviews with staff.

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 any person who has reasonable grounds to suspect abuse shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that an incident that caused an injury to a resident for which they were transferred to the hospital and resulted in a significant change in their health condition was reported to the Director no later than one business day after the occurrence of the incident.

The day after a resident was transferred to the hospital, the hospital informed the Home that the resident sustained a significant change in their condition. The incident was not reported to the Director until two business days later.

Sources: A CI report and an interview with the DOC. [s. 107. (3)]

2. The licensee has failed to ensure that the written incident report related to a resident's fall with injury and significant change in their condition included the long-term care actions planned to correct the situation and prevent recurrence.

A resident fell and sustained a serious injury and resulted in a significant change in their condition.

The CI report was not amended to include long-term actions to prevent recurrence. The DOC acknowledged this.

Sources: A CI report and an interview with the DOC. [s. 107. (4) 4.]

Issued on this 24th day of June, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JANET GROUX (606), DANIELA LUPU (758)
Inspection No. / No de l'inspection :	2021_876606_0011
Log No. / No de registre :	022152-20, 000628-21, 004502-21, 005838-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 10, 2021
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Midland Gardens Care Community 130 Midland Avenue, Scarborough, ON, M1N-4E6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lora Monaco

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

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

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 6 (7) of the LTCHA.

Specifically, the licensee shall:

a) Ensure that residents #001 and #003 receive care as set out in their plan of care in relation to falls prevention.

b) Conduct weekly audits for three months for residents #001 and #003 to ensure that interventions for falls prevention and management are followed. These audits should be documented and include the date and time, the name the resident who has been audited, the name of the person conducting the audit, the results of the audit and actions taken. A copy of the audits must be kept available in the home.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the care set out in the plan of care related to falls prevention was provided to residents #001 and #003 as specified in the plan of care.

A) A Critical Incident (CI) submitted to the Ministry of Long-Term Care (MLTC) reported resident #001 fell and sustained an injury.

Resident #001 was at risk for falls. Their plan of care directed the staff to ensure resident #001 used a specific falls prevention device at all times. During an observation, resident #001 was not using the specified falls prevention device as stated in their plan of care. This was acknowledged by a Registered Nurse (RN).

Failing to ensure that the plan of care related to a specified falls prevention device was implemented as outlined in the plan of care resulted in actual harm to resident #001.

Sources: A CI report, observations of resident #001, resident #001's clinical records and interviews with staff.

B) Resident #003 was at at risk for falls. Their plan of care directed staff to ensure that an specified falls prevention equipment was applied in their room and that resident #003 used a particular falls prevention device when they were in bed.

During an observation, resident #003 did not have the specified falls interventions in place as specified in resident #003's plan of care.

Failing to ensure that falls prevention measures were implemented for resident #003 as per their plan of care put the resident at further risk for falls injuries.

Sources: resident #003's clinical records, an observation of resident #003, and interviews with staff.

2. The licensee has failed to ensure that when a resident had a change in their condition, their plan of care was reviewed and revised.

Resident #001 was at risk for falls related to their medical conditions.

In 2021, resident #001 had a number of falls on identified dates without injury. They were reassessed to have specific risk factors that could cause them to fall. The assessments stated the resident would need one person for care, and for staff to ensure they implemented a couple of specific falls prevention interventions. However, review of resident #001's plan of care was not updated as required to include the recommended falls prevention interventions until an identified date.

On an identified date, resident #001 was transferred to the hospital after they fell and was diagnosed with a serious injury. Upon readmission, resident #001 was

reassessed and was identified with a change in their condition. A specific intervention was implemented on an identified date to manage the resident's fall risk but was not included in the resident's plan of care as required.

During a number of observations, staff initiated a number of falls interventions for resident #001. However, the falls interventions applied by staff were inconsistent during each observation. A review of the resident's plan of care showed the falls interventions observed were not included in the resident's plan of care. The Falls Lead acknowledged that the resident's plan of care should have been reviewed and updated after they had a change in their condition to include the recommended falls interventions.

Failing to ensure that a resident's plan of care was reviewed and revised in terms of their falls management could have put the resident at further risk of falls and injuries.

Sources: observations of resident #001, review of their clinical records, and interviews staff and the Falls Lead.

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

Severity: Failing to ensure that the care was provided as outlined in resident #001's and #003's plan of care resulted in actual harm to resident #001 and increased the risk of harm to resident #003.

Scope: The scope of this non-compliance was a pattern as two out of the three residents reviewed did not receive care as set out in their plan of care.

Compliance History: Three written notifications (WN), two voluntary plans of correction (VPC) and one compliance order (CO) which was complied with, were issued to the home related to this section of legislation in the past 36 months.

(758)

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

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 002

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

Linked to Existing Order / Lien vers ordre existant: 2020_767643_0020, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee shall:

1) Review with all registered staff the home's policy regarding medication administration. Reinforce the requirement to administer a medication on time and the requirement to document the medication administration at the time of administration.

2) Involve the interdisciplinary team to develop and implement interventions to address the reason(s) that is preventing residents #006, #007, #013, #015, #017, and #018 from taking their medications as ordered by the physician and as scheduled.

Grounds / Motifs :

1. Compliance order #001 related to O. Reg. 79/10, s. 8(1) (b) from inspection #2020_767643_0020 issued on November 2, 2020, with a compliance due date (CDD) of March 5, 2021, is being re-issued as follows:

The licensee has failed to ensure that the Home's "Medication Pass" policy was complied with for residents #006, #007, #013, #015, #016, #017 and #018.

As required by the Ontario Regulation 79/10, s. 114 (2) the licensee was to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The Home's "The Medication Pass" policy required the registered staff to administer a medication by following the rights to medications administration and included the right resident, medication, dosage, route, reason, time, and documentation.

Resident #006, #007, #013, #015, #016, #017 and #018's medication audits from Point Click Care (PCC) for identified dates showed a number of medications that were scheduled at specified times were administered late.

The medication audit showed a number of registered staff members failed to follow the Home's medication pass policy.

The Director of Care (DOC) acknowledged medications could be given one hour prior to or one hour after the scheduled administration time.

RPN #119 said they administered resident #006, #016, #017, and #018's medications on time but forgot to document in the electronic Medication Administration Records (e-MARs) until later.

RPN #123 acknowledged they were not able to administer resident's #013, #017, and #018's on time because the residents refused the medications or the resident were asleep.

RPN #119 and #123 acknowledged that they did not follow the Home's medication administration policy.

Failure to follow the Home's medication pass policy could cause the residents to have adverse effects related to their medications and put their health condition at further risk of harm.

Sources: The Home's "The Medication Pass" policy, Resident #006, #007, #013, #015, #016, #017 and #018 medication audits in PCC, and staff interviews.

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

Severity: The severity of the noncompliance was identified as minimal risk as residents medications were not administered as scheduled.

Scope: The scope of the noncompliance was identified as widespread as seven of the seven residents reviewed were affected.

Compliance history: The licensee continues to be in noncompliance with s. 8(1)(b) of O. Reg. 79/10 resulting in a compliance order (CO) being re-issued. CO #001 was issued on November 2, 2020, during inspection #2020_767643_0020 with a compliance due date of March 5, 2021. In the past 36 months, an CO and a Written Notification (WN), Voluntary Plan of Correction (VPC) were issued in the same section of the legislation, all of which have been complied. (606)

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

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

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 10th day of June, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Janet Groux

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