Ontario

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 6, 2017	2017_606563_0014	013220-17	Resident Quality Inspection

Licensee/Titulaire de permis

MEADOW PARK (LONDON) INC
689 YONGE STREET MIDLAND ON L4R 2E1

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

MEADOW PARK (LONDON) INC.
1210 SOUTHDALE ROAD EAST LONDON ON N6E 1B4

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

MELANIE NORTHEY (563), AMIE GIBBS-WARD (630), NANCY SINCLAIR (537), NEIL KIKUTA (658)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): July, 17, 18, 19, 20, 21, 24, 25, 26, 27, and 28, 2017

The following intakes were inspected at the same time as the RQI:
017329-17 - Follow Up Inspection related to Skin & Wound Compliance Order (CO) #001 issued May 25, 2017
029630-16 - Follow Up Inspection related to Medications Immediate CO #901 issued February 6, 2017

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Staff Educator, the Resident Assessment Instrument Coordinator, the Environmental Services Supervisor, the Life Enrichment Coordinator, the Restorative Care Coordinator, a Restorative Aide, the Physiotherapy Assistant, a Housekeeping Aide, the Silver Fox Pharmacy Director of Projects and Innovation, the Silver Fox Pharmacy Chief Operating Officer, the Silver Fox Pharmacy Manager, the Pharmacy Consultant, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Behavioural Supports Ontario Personal Support Worker, family members and residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **5 WN(s)**
- **3 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	Legendé 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. 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 has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin assessment.

The licensee has failed to comply with Order #001, Complaint Inspection #2016_419658_0015, with a compliance date of June 30, 2017 related to ensuring that all registered staff were re-educated on the home's skin program.

Ontario Regulation 79/10, s. 50(3) defines altered skin integrity as the potential or actual disruption of epidermal or dermal tissue.

A) A resident was observed with a dressing in place. The Registered Practical Nurse (RPN) verified that the resident had an area of altered skin integrity and a treatment plan was in place.

Record review of online progress notes documented in PointClickCare (PCC) stated that the resident had a physician's order for treatment to the area of altered skin integrity.

The Staff Educator said that they were the skin and wound lead for the home and

explained that registered staff were required to complete a skin assessment under the assessments tab in PCC, as well as a progress note for any area of altered skin integrity. Record review showed that a skin assessment and progress note were not completed for the resident.

The Staff Educator acknowledged that a skin assessment was not completed for the resident and that an assessment was required to be completed for all area of altered skin integrity. The Staff Educator also acknowledged that education related to Order #001 was not provided to all registered staff in the home, and that the entire skin and wound program developed by the home was not re-educated to registered staff by the compliance date of June 30, 2017.

The licensee has failed to ensure that altered skin integrity, including skin breakdown, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

B) A resident sustained an injury that required a dressing to a wound.The progress notes in PointClickCare (PCC) stated that a dressing was changed.

Record review showed that a skin assessment and progress note were completed that identified an area of altered skin integrity.

The Staff Educator explained that registered staff were expected to immediately complete an assessment for residents with altered skin integrity and acknowledged that a skin assessment and progress note were not completed until several days after the resident sustained an injury that required a dressing.

The licensee failed to ensure that the resident's area of altered skin integrity received a skin assessment by a registered staff member. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin tears, was assessed by a registered dietitian.

Record review of progress notes in PointClickCare (PCC) showed that the resident developed an area of altered skin integrity. A progress note was completed by the Registered Practical Nurse (RPN). The assessment identified that the skin care co-ordinator and physician were notified, but that a dietary referral was not completed.

The RPN stated that they had not sent a referral for the resident's altered skin integrity, and would only complete a referral to the Registered Dietitian (RD) when the area of altered skin integrity did not improve or worsened.

The RD explained that any impediment of skin integrity should be referred to and assessed by the RD and told the inspector that a referral was not completed for the resident's altered skin integrity.

The licensee failed to ensure that a dietary referral and RD assessment was completed related to the resident's altered skin integrity.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. There is a compliance history of this legislation being issued in the home on April 2, 2015 as a Written Notification during Critical Incident Inspection #2015_416515_0009 and on May 25, 2017 as Compliance Order #001 during Complaint inspection #2016_419658_0015. [s. 50. (2) (b) (iii)]

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. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

Findings/Faits saillants :

The licensee of the long-term care home failed to develop an interdisciplinary medication management system that provided safe medication management, as evidenced by:

1. The licensee failed to comply with O. Reg. 79/10, s.126, by failing to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

2. The licensee failed to comply with O. Reg. 79/10, s 129 (1) (b), by failing to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

3. The licensee failed to comply with O. Reg. 79/10, s. 130 (3), by failing to ensure that a monthly audit was undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies, and that immediate action was taken if any discrepancies were discovered.

4. The licensee failed to comply with O. Reg. 79/10, s. 133, by failing to ensure that a drug record was established, maintained and kept in the home for at least two years, in which was recorded the following information in respect of every drug that was ordered and received in the home:
1. The date the drug was ordered
2. The signature of the person placing the order
3. The name, strength and quantity of the drug
4. The name of the place from which the drug was ordered
5. The name of the resident for whom the drug was prescribed, where applicable
6. The prescription number, where applicable
7. The date the drug was received in the home
8. The signature of the person acknowledging receipt of the drug on behalf of the home
9. Where applicable, the information required under subsection 136(4).

5. The licensee failed to comply with O. Reg. 79/10, s. 135, by failing to ensure that every medication incident involving a resident and every adverse drug reaction was:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.
In addition, the licensee failed to ensure that,
(a) all medication incidents and adverse drug reactions were documented, reviewed and

analyzed;
(b) corrective action was taken as necessary; and
(c) a written record was kept of everything.
The licensee failed to ensure that,
(a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions;
(b) any changes and improvements identified in the review were implemented; and
(c) a written record was kept of everything.

6. The licensee failed to comply with O. Reg. 79/10, s. 8 (1) (b), by failing to ensure that a plan, policy, protocol, procedure, strategy or system that is required by the Long-Term Care Homes Act, 2007 or O. Reg. 79/10, was complied with.

Inspectors reviewed the licensee's current policies, the policies and procedures of Silver Fox Pharmacy, the drug records related to ordering and receiving medication, the monthly audits of controlled substance shift counts, the monthly audits completed by Silver Fox Pharmacy, the Medication Incident Notices/Forms, the education and training materials presented by Silver Fox Pharmacy, and the Electronic Medication Administration Records (eMAR). Inspector(s) interviewed staff of the licensee and representatives of the pharmacy service provider, Silver Fox Pharmacy. Inspectors completed observations of the medication rooms, medication carts, medication refrigerators, emergency medication supply, medication administration, and the drug destruction of controlled substances and non-controlled substances. Record reviews, interviews and observations identified non-compliance with the following requirements.

1. To achieve compliance with O. Reg. 79/10, s. 114 (1), the licensee was to develop an interdisciplinary medication management system that provided safe medication management. As part of Compliance Order (CO) #901 issued during Critical Incident (CI) inspection #2016_254610_0033, the licensee was required to educate all registered staff regarding the policy and procedures for unused or wasted medication for storage, and implement the procedure on administering medications from properly labelled vials, packages, strip pouches, and blister packs dispensed from the home's pharmacy service provider.

The licensee failed to comply with O. Reg. 79/10, s. 126, by failing to ensure that drugs remained in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

The Silver Fox Pharmacy Policy and Procedure Educational Session by PowerPoint was presented to all registered staff in March 2017 with respect to safe storage of medication. The registered staff were instructed that all medication should remain in their original Silver Fox Pharmacy labelled container until they were administered to an individual. Unused or wasted medication should be stored separately from active medication in a locked area until destruction.

The "Resident Rights, Care and Services - Medication Management - Administration of Medications Policy Version 3" revised July 20, 2017 stated that at the time of medication administration, the registrant will ensure that the medication was properly packaged and labeled and would administer medications only from properly labelled files, packages, strip pouches, blister packs dispensed from pharmacy, and/or properly labelled government stock pharmaceuticals.

The “Safe Storage of Medication Policy 5.1.” dated June 2016 stated all medication should remain in their original Silver Fox labelled container until they were administered to an individual.

The "Resident Rights, Care and Services - Medication Management - Drug Storage" policy with a revised date of October 7, 2013 (2013-10-07) stated the registered staff members administering medications would ensure that all drawers and bins of the medication cart were properly labelled as applicable and that discontinued or outdated medications were removed immediately from the medication cart, refrigerator, or government stock cupboards.

The “Medications Systems Audit” for an identified home care area was completed by the Silver Fox Pharmacy Director of Projects and Innovation (DPI). The audit stated, "Ensure medication capsules are kept in the original pharmacy labelled box. Most eye drops and medication cartridges are labelled with date opened however found some not labelled." An audit was also completed by the DPI for another home care area and documented that drugs were not stored in the original packaging.

Inspectors observed the medication cart and noted the following:
• In a marked container, medication capsules were not in the original labelled package, but the labelled portion of the package was ripped off and placed in the marked container,
• Blue coloured inhaler with no pharmacy label, but had paper tape covering the outside

of the inhaler with a hand written label of a resident's name,
• Unlabelled eye drops, and
• Top drawer of the medication cart had one round white tablet and an oblong pink speckled tablet outside of the original packaging and sitting loose among other medication supplies.

The RPN and RN could not identify which resident the two loose tablets in the top drawer of the medication cart belonged to. The RN suspected it might be from the emergency stock. Both registered staff acknowledged that all medications were to remain in the original labelled container or package provided by the pharmacy.

Inspectors observed the medication cart and noted one medication container with a specific Drug Identification Number (DIN) and prescription number (Rx) from "Emergency Supply" with a handwritten label in blue pen with a resident's name.

The RPN acknowledged that the medication pen for the resident was illegible, and verified that there was no name on the medication pen, only a hand written name on the box.

Inspectors observed another medication cart and noted the following:
• In a marked container, medication capsules were not in the original labelled pharmacy package,
• Outside a marked container, a pre-filled syringe was unlabelled and outside of the original labelled package located in another drawer,
• In an unmarked container, medication capsules were not in the original labelled package and sitting beside an inhaler,
• Medication pen container and the medication pen for a resident were not labelled with an original label from pharmacy, and
• Medication patches in a box with no pharmacy label and a handwritten label with the name of a resident.

The RN acknowledged that the label for the medication pen was a label that came from the resident's chart and was not the original label from pharmacy. As for the medication patches, the RPN verified that there was a physician's order and the patches were not labelled with an original label from pharmacy.

Inspectors observed another medication cart and noted the following:
• In a marked container, medication capsules were not in the original labelled package,

• In an unmarked container, medication capsules were not in the original labelled package and sitting beside an inhaler,
• One bottle of medication syrup did not have an original pharmacy label, and the last name of a resident was handwritten on the front of the bottle, and
• In an unmarked container in the fifth drawer, there was one unlabelled medication puffer and one medication patch located outside of the original labelled package from pharmacy with a handwritten label that documented a resident's first name.

The RN acknowledged that the Ventolin puffer was unlabelled and was unsure who the puffer belonged to. The RN also explained that the unlabelled box in the fifth drawer with various medications was a box that contained medications for destruction.

The Staff Educator verified that all medications should be in their original labelled pharmacy package.

The licensee failed to ensure that drugs remained in the original labelled container or package provided by the Silver Fox Pharmacy service provider until the medications were administered to a resident or destroyed.

2. To achieve compliance with O. Reg. 79/10, s. 114 (1), the licensee was to develop an interdisciplinary medication management system that provided safe medication management. As part of CO #901 issued during CI inspection #2016_254610_0033, the licensee was required to educate and train all registered staff on safe storage of controlled substances in double locked storage areas or in a separate locked area within the locked medication cart.

The licensee failed to comply with O. Reg. 79/10, s. 129 (1) (b), by failing to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area.

The Silver Fox Pharmacy Policy and Procedure Educational Session by PowerPoint was presented to all registered staff in March 2017 with respect to the safe storage of medication. Controlled substances must be stored separately in a double locked area and the location of the emergency controlled substances may be within a medication cart or in the "stat box" located in the home in a locked medication room.

The "Emergency Medication Home Supply Policy 3.10." dated June 2016 stated, "if controlled substances are included in the emergency medication home supply, storage in

a locked and secure area will be determined by the home."

Inspectors observed a specific medication room and noted that inside one of the refrigerators contained a locked black box. The RN unlocked the black box in the fridge and there was an injectable controlled substance inside. Inspectors reviewed the finding with the Staff Educator and the Director of Care (DOC). The DOC acknowledged that the controlled substance should be stored in a separate, double-locked stationary cupboard and that the black box was not stationary.

The Staff Educator acknowledged that the locked black metal boxes in the refrigerators in each home care area would contain controlled substances, but that not all boxes necessarily have a controlled substance in them. All home care area medication room refrigerators were observed and only one medication refrigerator had a controlled substance contained in the black locked box.

An email titled “lock boxes” from the Silver Fox Pharmacy Director of Projects and Innovation to the Staff Educator stated, "there is nothing in the act other than it needs to be double locked which it is" “keeping it in the lock box in the fridge in a locked med room should be sufficient."

The "Resident Rights, Care and Services - Medication Management -Narcotics and Controlled Substances" policy with a revised date of October 7, 2013 (2013-10-07) stated all narcotics shall be stored in a permanently affixed cabinet, under double lock at all times accessible only by a registered staff member.

The "Resident Rights, Care and Services - Medication Management - Drug Storage" policy with a revised date of October 7, 2013 (2013-10-07) stated the Director of Care would ensure that medications were stored and secured in keeping with the legislation. The registered staff members administering medications would ensure that all narcotics were stored in a double locked, permanently affixed compartment within the general medication cart and or medication room.

The licensee failed to ensure that the injectable controlled substance was stored in a separate, double-locked stationary cupboard in the locked area.

3. To achieve compliance with O. Reg. 79/10, s. 114 (1), the licensee was to develop an interdisciplinary medication management system that provided safe medication management. As part of CO #901 issued during CI inspection #2016_254610_0033, the

licensee was required to conduct monthly audits of the daily count sheets for controlled substances, evaluate the information gathered through the monthly audits to determine if there were any discrepancies and take immediate action if any discrepancies were discovered. The actions taken were to be documented.

The licensee failed to comply with O. Reg. 79/10, s. 130 (3), by failing to ensure that a monthly audit was undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies, and that immediate action was taken if any discrepancies were discovered.

The Silver Fox Pharmacy Policy and Procedure Educational Session by PowerPoint was presented to all registered staff in March 2017 with respect to controlled substance documentation and that the home must complete a monthly audit of the daily controlled substance count sheets and to immediately report any discrepancies to the Director of Care.

The Staff Educator shared that the medication audits were completed once a month. The Staff Educator, the Director of Care (DOC) and the Resident Assessment Instrument Coordinator (RAI-C) visited each nursing station and completed the audit and it was the same audit that pharmacy used. The Staff Educator stated that each drug record book, medication cart, and treatment cart was audited and that this was documented as part of the audit. Inspector asked what the process was if there was a discrepancy in the drug record and the Staff Educator shared that there would be follow up with the registered staff involved. Also, daily narcotic count sheets were audited monthly and the home had created an additional controlled substances audit to encourage nurses to do it themselves once a month before management audits.

The "Controlled Substance Process Audit" referenced O. Reg. 79/10, s. 130 where the daily count sheets of controlled substances were to be audited monthly to identify any potential discrepancies and take immediate action. The "Controlled Substance Shift Count" process was to audit that two signatures were present at each shift count and that the shift count matches the administration record. The following was documented as part of this audit for the following months in the following home care areas:

April 2017:
• An identified home area: Staff Educator and the RAI-C completed the audit where the controlled substance shift count had one missing entry and was flagged for follow up.
• Another identified home area Staff Educator and the RAI-C completed the audit where

there was one missing signature on the Individual and Shift Count sheets and flagged for follow up.

May 2017:
• All four home areas were not completed

June 2017:
• Two home areas were not completed

July 2017: as of July 28, 2017
• All four home areas were not completed

The “Medication Systems Audit” was also to be completed monthly for each home care area which identified whether an audit of the daily count sheets of controlled substances was performed monthly by the home. All Medication System Audits completed in April, May, June and July 2017 identified with a “Y” for yes that an audit was completed. However, there was no documented evidence of a controlled shift or individual count audit for all home care areas for May, or for two home care areas in June and although the medication system audits for July documented that the daily count sheets were audited, there was no documented evidence that this occurred.

The “Controlled Substance Documentation Policy 5.3.” dated June 2016 stated an audit of the daily controlled substance count sheet was to be completed by the staff at the home on a monthly basis and all discrepancies must be reported immediately to the Director of Care.

The Staff Educator shared that the registered nursing staff did not receive instruction on how to complete or when to complete the audit tools and acknowledged that the "Controlled Substance Process Audit" did not identify an audit time-frame. The Inspector asked where corrective action was documented in the audits and who was responsible for the follow up and the Staff Educator did not know. The Staff Educator also verified that the "Controlled Substance Process Audits" were not being completed monthly for each home care area.

The RAI-C also acknowledged that registered staff were not instructed on how to complete the audit tools and that the registered staff were to let them know right away if there was a discrepancy during any narcotic counts.

The Staff Educator and Inspector reviewed "Controlled Substance Process Audit" for one home care area where the "Shift Count" was marked "Y" for "yes" indicating that the shift count had two signatures present at each shift count. The Staff Educator could not verify the time period of this audit, and acknowledged that the registered staff did not receive directions related to the use of the form except that they were to work through it. The Staff Educator thought that the form may be just for the day indicated and not an audit for the month as required. The Inspector reviewed the "Medications System Audit" completed by the DOC for a home care area where under the "Documentation" heading "Y" for yes was answered that "an audit of the daily count sheets of controlled substances is performed monthly by the home". There were no comments documented related to any discrepancies noted. The Inspector reviewed the "Controlled Substance Shift Count" for a particular home care area for a missing signature on the evening shift for the incoming registered staff member. The Staff Educator acknowledged that shift count required two registered staff signatures at each shift count every day and that the Medication System Audit did not document the discrepancy identified.

The “Controlled Substance Shift Counts” completed for all four home care areas had missing signatures of the registered staff for both the incoming and outgoing staff member on multiple days. The records were missing for one particular home care area. The DOC acknowledged that the controlled substance shift counts were missing for one week for one home care area.

The DOC was shown inconsistencies in audit completion and documentation. The DOC acknowledged that the "Controlled Substance Process Audit" does not identify a time-frame the daily count sheets for controlled substances were reviewed. The DOC also verified that the controlled substance process audits were not completed for May 2017 and only completed for two home care areas in June 2017. Inconsistencies among controlled substance process audits for daily shift counts and medication systems audits were reviewed. The DOC acknowledged inconsistencies and that audits completed in the home were not matching the information in the daily shift counts. The documentation as part of the controlled substance process audits was not capturing the actual discrepancies identified by the Inspectors during the record review of the shift count sheets. The DOC shared that there would be follow up with the registered staff related to missing signatures identified on the controlled substance shift count sheets, but acknowledged that as part of the June audit, there was no follow up with the evening registered staff member. The DOC also acknowledged that there was no documented follow up related to the actions taken for the missing signatures identified on the April 2017 "Controlled Substance Shift Count" audit of the individual and shift daily count

sheets.

The licensee failed to ensure that a monthly audit was undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies, and that immediate action was taken if any discrepancies were discovered.

4. To achieve compliance with O. Reg. 79/10, s. 114 (1), the licensee was to develop an interdisciplinary medication management system that provided safe medication management. As part of CO #901 issued during CI inspection #2016_254610_0033, the licensee was required to educate and train all registered staff regarding the policy and procedure for maintaining a drug record. Also, to implement a system for establishing accurate and up-to-date drug records that included the information as described in s. 133 for every drug that was ordered and received in the home.

The licensee failed to comply with O. Reg. 79/10, s. 133, by failing to ensure that a drug record was established, maintained and kept in the home for at least two years, which recorded the following information, in respect of every drug that was ordered and received in the home:
1. The date the drug was ordered
2. The signature of the person placing the order
3. The name, strength and quantity of the drug
4. The name of the place from which the drug was ordered
5. The name of the resident for whom the drug was prescribed, where applicable
6. The prescription number, where applicable
7. The date the drug was received in the home
8. The signature of the person acknowledging receipt of the drug on behalf of the home
9. Where applicable, the information required under subsection 136(4).

The Silver Fox Pharmacy Policy and Procedure Educational Session by PowerPoint was presented to all registered staff in March 2017 with respect to the drug record. All medications received at the home must be documented in the drug record. If procedure has been followed correctly all receiving information will be accompanied by ordering details. The legislation r. 133 was reviewed with the following information with respect to every drug that was ordered and received in the home. It was reviewed that the drug record should be stored in the home for a minimum of two years. The training included a review of how to complete the drug record form for ordering new medications and that it was completed by the ordering nurse and completed by the receiving nurse.

The “Ordering Prescriptions Policy 3.2.” dated June 2016 stated registered staff were to enter the prescription information into the appropriate boxes on the drug record page or peel the reorder label from the desired medication and place it in the drug record in the next available space. Initial and date in the appropriate boxes and repeat this process for all items re-ordered.

The “Drug Record Policy 3.3.” dated June 2016 stated the drug record should be stored in the home for a minimum of two years. Once the new or repeated medication has been received at the home, the person checking it will sign and date, record the new prescription number and the quantity received. Any staff member may now check the "Drug Record" to verify that the medication has been received within the home.

The "Resident Rights, Care and Services - Medication Management - Narcotics and Controlled Substances" policy with a revised date of October 7, 2013 (2013-10-07) stated a count of narcotics shall be completed by the off going and incoming registered staff member at change of shift and whenever an exchange of medication keys takes place.

The Staff Educator shared that there was a lot of time spent reviewing the drug records during the PowerPoint education session and the home was auditing each drug record book and if there was a discrepancy in the drug record, there would be follow up with the registered staff involved. The Staff Educator also shared that drug records were given to the Director of Care (DOC) and kept in the DOC office.

The narcotic and controlled substance destruction was observed with the Consultant Pharmacist (CP) and the Registered Nurse (RN) in attendance. The CP shared that the original individual administration record should be kept in the home for two years and once the narcotic destruction has been completed, the original records were given to the DOC/Administrator.

The "Drug Records" dated June 1 to 30, 2017 in every home care area was missing information documented for drugs ordered and received in the home:
• One home care area had missing information for approximately 70% of medications ordered and received,
• One home care area had missing information for approximately 50% of medications ordered and received,
• One home care area had missing information for approximately 55% of medications ordered and received, and

• One home care area had missing information for approximately 65% of medications ordered and received.

The Staff Educator and the Inspector reviewed the drug record where the resident's specific medication was documented as ordered with no prescription number or quantity indicated. Reviewed the drug record where another resident's medication was documented as ordered with no prescription number or quantity indicated. The Staff Educator acknowledged mandatory information was missing.

The Medications Systems Audit was completed by the Silver Fox Pharmacy Director of Projects and Innovation where the audit documented "N" for "no" for "the drug record was readily available and maintained" with a comment which stated the drug record was missing several entries by both the ordering and receiving nurse in April, May and July for three of four home areas.

During a telephone interview, the Director of Projects and Innovation, the Chief Operating Officer, and the Pharmacy Manager reviewed the Medication Systems Audit shared that the drug records reviewed as part of this audit would be for the time period of one month.

The "Medication Systems Audit" was completed by the RAI-C for each home care in July 2017. Two home care area audits were completed with an identified discrepancy related to a small number of missing signatures on the drug record.

The Director of Care (DOC) acknowledged that there were multiple areas of missing documentation for both ordering and receiving of medications on the drug records for all four home care areas. The DOC verified that the drug records were not maintained.

The licensee failed to ensure that the drug records were maintained and recorded the information required in s. 133 for every drug that was ordered and received in the home.

5. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

In addition, the licensee failed to ensure that,
(a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed;
(b) corrective action was taken as necessary; and
(c) a written record was kept of everything.

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

The Silver Fox Pharmacy Policy and Procedure Educational Session by PowerPoint was presented to all registered staff in March 2017 with respect to medication incidents. The training materials described a medication incident as a preventable event associated with the prescribing, ordering, dispensing, storing, labeling, administering or distributing of a drug, or the transcribing of the prescription, and included an active omission or commission, whether or not it resulted in harm, injury or death to a resident or a near miss event where the incident does not reach a resident but had it done so, harm, injury or death could have resulted. Registered staff reviewed common medication incident types, reporting requirements, quality improvement, investigation, and appropriate and immediate actions taken. Registered staff also reviewed the documentation requirements for the medication incident form.

The "Resident Rights, Care and Services - Medication Management - Medication Incident Policy Version 2" revised July 20, 2017, stated a medication incident shall be defined as a preventable event associated with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a prescription. Upon identification of a medication error, the individual identifying the error would assess the resident for any signs or symptoms of reaction to the error, notify the physician, the resident and the resident's SDM, report the incident to the attending physician, Director of Care (DOC), pharmacist; then initiate and complete the internal medication incident report and forward the completed report to the DOC, physician and pharmacist and document in the progress notes the status of the resident, actions taken and further follow up action required.

The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. In addition, the licensee failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analysed; corrective action was taken as necessary; and a written record was kept of everything.

A "Medication Incident Notice" was completed for a resident. The incident form did not identify the staff member who made the medication error, or the staff member who identified the error. Multiple medications were charted as given at 0800 hours, but the unopened medication package for 0800 hours was found in the medication cart at bedtime. The incident form documented that the event was communicated to "resident/Power of Attorney (POA)", "Silver Fox Pharmacy", "On call" prescriber and the "DOC". The DOC acknowledged that the RPN was responsible for the dose omission, and that there was no corrective action for the RPN documented. During a telephone interview, the Inspector reviewed the medication incident with the Silver Fox Pharmacy Director of Projects and Innovation, the Chief Operating Officer, and the Pharmacy Manager and they verified that the incident was not faxed to pharmacy. The Silver Fox Pharmacy Chief Operating Officer shared that the pharmacy was to receive all medication incidents, especially an omission.

A "Medication Incident Form" was completed for a resident. The form documented that a medication for noon was missed. Incident type was documented as "dose omission". The incident form was signed by the DOC. The DOC verified that follow up with the staff member depended on the seriousness of the medication incident and the staff would be called immediately or they would wait until the staff member's next scheduled shift. The DOC verified that follow up with the Registered Practical Nurse (RPN) did not occur and acknowledged that there should always be a follow up with the staff member. The RPN Schedule documented that there were four scheduled shifts between Monday and Friday where the DOC could have followed up with the RPN and did not.

A "Medication Incident Notice" was completed for a resident. The medication was described with just the name and no other description documented. The outcome of the incident was left blank. The RPN reported the narcotic count sheet was missing from the narcotic ampules. RN took the narcotic count sheet home and returned the form to the

resident's chart. The RPN and the RN did not complete the daily count sheet. The DOC verified that the medication incident notice lacked the appropriate documentation and was left incomplete. During a telephone interview, the Inspector reviewed the medication incident with the Silver Fox Pharmacy Director of Projects and Innovation, the Chief Operating Officer, and the Pharmacy Manager and they verified that the Medication Incident Notice completed for the resident was not faxed to pharmacy and they verified that pharmacy would expect notification of this type of error. The Director of Projects and Innovation shared they would like to look at all incidents from a pharmacy perspective and all incidents were tracked by pharmacy regardless of the origin of the error.

A "Medication Incident Notice" was completed for a resident. A specific medication was discontinued as signed by the Physician. A new batch of medication strips arrived containing the discontinued medication. The DOC acknowledged that the medication incident notice should have been faxed to pharmacy. During a telephone interview, the Inspector reviewed the medication incident with the Silver Fox Pharmacy Director of Projects and Innovation, the Chief Operating Officer, and the Pharmacy Manager and they verified that this incident was not faxed to pharmacy, that pharmacy was faxed the discontinuation of the medication several days later. They shared that the expectation would be for the home to fax the discontinued order on the same day it was discontinued. Review of a copy of the fax verified receipt of the physician's orders to pharmacy was dated several days after the discontinuation of the drug.

A "Medication Incident Notice" was completed for a resident. The Registered Practical Nurse (RPN) administered two tablets instead of the one tablet ordered. Review of the progress notes verified there was no documentation related to the overdose monitoring or assessment of the resident. The DOC acknowledged there was no follow up monitoring or assessment of the resident documented as part of the resident's clinical record. The DOC also verified that there was no follow up with the RPN and nothing documented in the staff member's Human Resource (HR) file. During a telephone interview, the Inspector reviewed the medication incident with the Silver Fox Pharmacy Director of Projects and Innovation, the Chief Operating Officer, and the Pharmacy Manager and they verified that this incident was not faxed to pharmacy and that it should have been faxed for their review.

The Staff Educator shared that the nurse who discovered the medication incident would fill out the form, take action as needed, and fax the form to pharmacy. The original goes to the DOC and the DOC takes corrective action.

The Director of Care (DOC) shared that they were unable to locate the Professional Advisory Committee (PAC) meeting minutes from the last meeting in March or April 2017. The DOC and the Administrator shared that the PAC meeting was pushed from April and scheduled for May 2017. The Administrator verified that the PAC meeting occurred on this date, but that there was no record of the meeting minutes found. The DOC acknowledged that there were five medication incidents documented in January, one in February and seven medication incident forms completed for March 2017. Both the DOC and Administrator acknowledged that there should be a written record of the quarterly review undertaken of the 13 medication incidents that occurred in the home since the time of the last review.

During a telephone interview, the Inspector reviewed the medication incident with the Silver Fox Pharmacy Director of Projects and Innovation, the Chief Operating Officer, and the Pharmacy Manager shared that although pharmacy reviews each medication incident, that a pharmacy summary would not have been completed unless it was a pharmacy error. All pharmacy errors were analyzed and summarized and the summaries were then faxed to the Administrator and DOC of the home. A quarterly review was to be undertaken of all medication incidents regardless of origin.

The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented with a record of the immediate actions taken to assess and maintain the resident's health. The incidents were not reported to the appropriate persons as described in O. Reg. 79/10, s. 135, corrective action was not taken as necessary and there was not a written record kept of everything. There was no documented evidence of a quarterly review undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review.

6. To achieve compliance with O. Reg. 79/10, s. 114 (1), the licensee was to develop an interdisciplinary medication management system that provided safe medication management. As part of Compliance Order (CO) #901 issued during Critical Incident (CI) inspection #2016_254610_0033, the licensee was required to educate and train all registered staff on the procedure in the home for the recording of the daily count sheets for controlled substances.

The licensee failed to comply with O. Reg. 79/10, s. 8(1)(b), by failing to ensure that the "Controlled Substance Documentation Policy 5.3." that was required by the Long-Term Care Homes Act, 2007 or O. Reg. 79/10, was complied with.

A) The "Controlled Substance Documentation Policy 5.3." dated June 2016 stated counts must be done at every shift change with two staff members on the controlled substance shift count record. Both staff members must be present and complete the count together. An audit of the daily controlled substance count sheet was to be completed by the staff at the home on a monthly basis and all discrepancies must be reported immediately to the Director of Care.

The Silver Fox Pharmacy Policy and Procedure Educational Session by PowerPoint was presented to all registered staff in March 2017 with respect to controlled substance documentation. Every change of staff required a shift count by two staff members on the controlled substance shift count record. Registered staff reviewed the count sheets as part of their education related to documentation.

One home care area "Controlled Substance Shift Count" had missing registered staff signatures on the day, evening and night shift on multiple dates.

The home care area medication room was observed. The RPN and the RN were present at the shift change controlled substance count and shared that two registered staff were required to count at each shift change and during a contingency count if there were any change in the registered staff at any other time.

Another home care area medication room was observed. The RPN acknowledged that there were missing signatures on the controlled substance shift counts and shared that registered staff received education not too long ago related to the completion and documentation of the narcotic shift count.

Another home care area medication room was observed. The controlled substance shift count records were missing registered staff signatures. The Registered Nurse (RN) explained that they had forgotten to sign the controlled substance shift count record and stated that they were present during the count with the outgoing night nurse. The RN shared they have received education on completing the narcotic count record during orientation, and also during a two day training session presented by pharmacy in early spring. The RN stated a controlled substance count was to be completed whenever there was a change in nurses.

Another home care area medication room was observed. The RN acknowledged that the signage on the controlled substance count sheet during the sign in of the evening shift was not completed and that the expectation was that both registered staff were to sign at

the time of the narcotic count.

The Staff Educator acknowledged that the shift narcotic count required two registered staff signatures at each shift count every day.

The DOC acknowledged there were multiple missing signatures on the controlled substance shift count and that there was no documented evidence that two staff were present for the narcotic shift counts on multiple occasions.

B) To achieve compliance with O. Reg. 79/10, s. 114 (1), the licensee was to develop an interdisciplinary medication management system that provided safe medication management. As part of Compliance Order (CO) #901 issued during Critical Incident (CI) inspection #2016_254610_0033, the licensee was required to educate all registered staff regarding the policy and procedures for unused or wasted medication for storage; and implement the procedure on administering medications from properly labelled vials, packages, strip pouches, and blister packs dispensed from the home’s pharmacy service provider.

The licensee was required by O. Reg. 79/10, s. 136 (1) to have a written drug destruction and disposal policy. O. Reg. 79/10, s. 136 (6) stated a drug was considered to be destroyed when it was altered or denatured to such an extent that its consumption was rendered impossible or improbable.

The licensee failed to comply with O. Reg. 79/10, s. 8 (1)(b), by failing to ensure the “Disposal of Non-Controlled Medications Policy 5.6.” and the "Resident Rights, Care and Services - Medication Management - Drug Disposal and Wasting of Medications and Wasting of Medications" policy that was required by the Long-Term Care Homes Act, 2007 or O. Reg. 79/10, was complied with.

The “Disposal of Non-Controlled Medications Policy 5.6.” dated June 2016 stated in preparation for waste pick up by the medical waste collection company; inhalers, liquid, nasal, eye and ear preparations were placed or opened and dumped in the buckets. The medication should be denatured, making consumption impossible or improbable, by using water or discontinued liquid medication to completely destroy the medication.

The "Resident Rights, Care and Services - Medication Management - Drug Disposal and Wasting of Medications and Wasting of Medications" policy with a revised date of July 20, 2017, stated drug destruction shall be completed by denaturing the contents of the

disposed medications in the medical waste disposal bucket.

A medication room was observed. The drug destruction waste bucket stored in the medication room had two full bottles of medication sitting in the bucket. The medication containers were not emptied into the bucket and could be removed by the Inspector. Registered Practical Nurse (RPN) explained that liquids should be emptied from their container before placement into the destruction bucket and that the medication from the two bottles should have been emptied.

C) To achieve compliance with O. Reg. 79/10, s. 114 (1), the licensee was to develop an interdisciplinary medication management system that provided safe medication management. As part of Compliance Order (CO) #901 issued during Critical Incident (CI) inspection #2016_254610_0033, the licensee was required to educate and train all staff on the licensee's policy and the legislative requirements for drug destruction of a controlled substance. This education will include training for all registered staff with respect to the licensee's drug destruction and disposal policy and how to complete the documentation record to ensure the following was documented: the date of removal of the drug from the drug storage area; the name of the resident for whom the drug was prescribed; the prescription number of the drug, the drug's name, strength and quantity, the reason for destruction; the date when the drug was destroyed; the names of the members of the team who destroyed the drug and the manner of destruction of the drug.

The licensee was required by O. Reg. 79/10, s. 136(1) to have a written drug destruction and disposal policy. O. Reg. 79/10, s. 136(4) stated that where a drug that was to be destroyed was a controlled substance, the drug destruction and disposal policy must provide that the team acting together shall document the following in the drug record:
1. The date of removal of the drug from the drug storage area.
2. The name of the resident for whom the drug was prescribed, where applicable.
3. The prescription number of the drug, where applicable.
4. The drug's name, strength and quantity.
5. The reason for destruction.
6. The date when the drug was destroyed.
7. The names of the members of the team who destroyed the drug.
8. The manner of destruction of the drug.

The licensee failed to comply with O. Reg. 79/10, s. 8(1)(b), by failing to ensure the "Disposal of Controlled Medications Policy 5.7." that was required by the Long-Term Care Homes Act, 2007 or O. Reg. 79/10, was complied with.

The Silver Fox Pharmacy Policy and Procedure Educational Session by PowerPoint was presented to all registered staff in March 2017 with respect to the licensee's drug destruction and disposal policy and how to complete the documentation record.

The "Disposal of Controlled Medications Policy 5.7." dated June 2016 stated the following information must be documented on the controlled substance administration record for the controlled medication to be destroyed:
• the prescription number,
• the date the drug was dispensed,
• the name of the resident,
• the medication name, strength directions and dosage, and
• the reason for destruction.

The narcotic and controlled substance destruction was observed with the Consultant Pharmacist and the Registered Nurse (RN) participating in the process. The following documentation errors were noted by the RN on the following five "Controlled Substance Administration Records"(CSAR):
1. The count documented that the amount remaining was indicated as one "1.0", but the quantity removed was "0.5". The RN stated the dose was taken from the as needed (PRN) medication card rather than from the dose for every six hours.
2. The CSAR was missing the second nurse signature for the removal date.
3. The CSAR was missing the removal date.
4. The CSAR was missing the reason for removal.
5. The CSAR was missing the second nurse signature for the removal date and the quantity removed did not match the quantity destroyed.

The DOC acknowledged there was missing information on the controlled substance administration records identified during the drug destruction.

D) To achieve compliance with O. Reg. 79/10, s. 114 (1), the licensee was to develop an interdisciplinary medication management system that provided safe medication management. As part of Compliance Order (CO) #901 issued during Critical Incident (CI) inspection #2016_254610_0033, the licensee was required to educate all registered staff regarding the policy and procedures for unused or wasted medication for storage; and implement the procedure on administering medications from properly labelled vials, packages, strip pouches, and blister packs dispensed from the home's pharmacy service provider.

The licensee was required by O. Reg. 79/10, s. 136(1) to have a written drug destruction and disposal policy. O. Reg. 79/10, s. 136(2)1 stated drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

The licensee failed to comply with O. Reg. 79/10, s. 8(1)(b), by failing to ensure that the "Safe Storage of Medication Policy 5.1." and "Disposal of Non-Controlled Medications Policy 5.6." that was required by the Long-Term Care Homes Act, 2007 or O. Reg. 79/10, was complied with.

The Silver Fox Pharmacy Policy and Procedure Educational Session by PowerPoint was presented to all registered staff in March 2017 with respect to safe storage of medications. All medication should remain in their original pharmacy label container until they are administered to an individual. Unused are wasted medication should be stored separately from active medication in a locked area until destruction.

The "Safe Storage of Medication Policy 5.1." dated June 2016 stated all medication should remain in their original Silver Fox labelled container until they were administered to an individual and unused wasted medication should be stored separately from active medication in a locked area until it can be returned to Silver Fox pharmacy.

The "Disposal of Non-Controlled Medications Policy 5.6." dated June 2016 stated medications awaiting destruction must be stored in a secure designated area within the home, separate from medications that are to be administered to the residents. In preparation for waste pick up by the medical waste collection company; inhalers, liquid, nasal, eye and ear preparations are placed or opened and dumped in the buckets.

An identified medication room was observed. The top drawer of the medication cart had two loose pills outside of the original or strip packaging from pharmacy. The RPN and the RN could not identify which resident the two tablets belonged to, but the RN suspected it might be from the emergency stock.

A medication cart was observed. The fifth drawer of the medication cart contained various medications for destruction sitting in a blue container:
• One unlabelled puffer
• One labelled puffer
• One labelled medication package

• One medication patch with handwritten resident initials

The Registered Nurse (RN) explained that the unlabelled box in the fifth drawer with various medications was a box that contained medications for destruction. The RN verified that the medications have been sitting in the box for a while and were not discontinued or stopped today. The RN acknowledged that the medications ready for destruction should not be left in the medication cart and should be denatured as soon as possible.

E) To achieve compliance with O. Reg. 79/10, s. 114 (1), the licensee was to develop an interdisciplinary medication management system that provided safe medication management. As part of Compliance Order (CO) #901 issued during Critical Incident (CI) inspection #2016_254610_0033, the licensee was required to educate all registered staff regarding the policy and procedures for unused or wasted medication for storage; and implement the procedure on administering medications from properly labelled vials, packages, strip pouches, and blister packs dispensed from the home's pharmacy service provider. Also, the licensee was required to develop a procedure to ensure expired medications were removed from the medication carts and evaluate the implementation of the procedure to ensure it was followed by all registered staff.

The licensee was required by O. Reg. 79/10, s. 136(1) to have a written drug destruction and disposal policy that provides for the ongoing identification, destruction and disposal of:
(a) all expired drugs;
(b) all drugs with illegible labels;
(c) all drugs that are in containers that do not meet the requirements for marking containers specified under subsection 156 (3) of the Drug and Pharmacies Regulation Act; and
(d) a resident's drugs where,
(i) the prescriber attending the resident orders that the use of the drug be discontinued,
(ii) the resident dies, subject to obtaining the written approval of the person who has signed the medical certificate of death under the Vital Statistics Act or the resident's attending physician, or
(iii) the resident is discharged and the drugs prescribed for the resident are not sent with the resident under section 128.

The licensee failed to comply with O. Reg. 79/10, s. 8(1)(b), by failing to ensure that medication policies that were required by the Long-Term Care Homes Act, 2007 or

O.Reg. 79/10, were complied with.

The Silver Fox Pharmacy Policy and Procedure Educational Session by PowerPoint was presented to all registered staff in March 2017. The registered staff were trained on the removal of medications from active the medication supply of all expired drugs, all drugs with illegible labels, all drugs that were in containers that do not meet the requirements for marking containers and the resident's drugs where the drug was discontinued, the resident dies, or the resident was discharged.

1) The "Resident Rights, Care and Services - Medication Management - Administration of Medications Policy Version 3" policy last revised July 20, 2017 stated registered staff would administer medications only from properly labelled files, packages, strip pouches, blister packs dispensed from pharmacy, and/or properly labelled government stock pharmaceuticals.

Inspectors observed a medication cart and noted a treatment cream with an illegible label with a resident’s name handwritten on the top of the bottle. The RPN acknowledged that the treatment cream’s original label provided by the pharmacy was illegible.

Inspectors observed the medication cart and noted a medication container from the “Emergency Supply” with a handwritten label in blue pen with a resident's name and the medication pen inside the container had an illegible label with no name on the pen. The RPN acknowledged that the medication pen was illegible, and verified that there was no name on the pen, only a hand written name on the box. The DOC also acknowledged that the medication pen label taken from emergency drug supply was illegible and have since ordered a new medication pen.

Inspectors observed the medication cart and noted a medication pen with an illegible label. The RN acknowledged that the resident’s medication pen label was illegible, that pharmacy should have been faxed for a new label, and the medication removed from the cart.

2) The "Resident Rights, Care and Services - Medication Management - Drug Disposal and Wasting of Medications and Wasting of Medications" policy last revised date of July 20, 2017 stated registered staff will remove medications which were discontinued, unused, expired, recalled, deteriorated, unlabeled and in containers with worn, illegible, damaged, incomplete or missing labels.

The medication room was observed. The medication cart had one bottle of medication that had expired in June 2017. The RPN acknowledged that the medication had an expiration date of June 2017.

The Staff Educator stated education was provided to all registered staff related to expired medications and staff were responsible for checking expiration dates before administration and placing expired medications into the white destruction buckets in each medication room. Expired medications were evaluated as part of the home audit to ensure no expired medications were in the medication carts.

An identified medication room was observed. The medication cart had one bottle of medication that had expired in June 2017. The RPN acknowledged that the medication expired in June 2017, and that all expired medications should be disposed according to the policy.

The medication room was observed. The medication cart had two bottles of medication that had expired in June 2017. The RN acknowledged that the medications expired in June 2017.

The Staff Educator provided a copy of an email related to "Drug Expiration" and shared that the Chief Quality & Clinical Services Officer from Silver Fox Pharmacy stated, "By definition, the products expire at the end of the month unless a date is specified."

The Medication Systems Audits completed in July 2017 for all four home care areas documented that medications past their date of use have been removed from the active stock, including expired medications. The DOC acknowledged that there were discrepancies between the information documented in the audit and what was observed in the medication carts.

3) The “Safe Storage of Medication Policy 5.1.” dated June 2016 stated all medications must be stored in a locked medication room or cabinet and unused medication should be stored in a locked area until it can be returned to Silver Fox Pharmacy.

The “Disposal of Non-Controlled Medications Policy 5.6.” dated June 2016 stated non-controlled medications that are to be disposed of must be stored in a secure designated area within the home.

The Medication Incident Notice completed for a resident had the strip package containing

multiple medications stapled to the medication incident report.

The Medication Incident Notice completed for a resident had the strip package containing medication tablets stapled to the medication incident report.

The DOC acknowledged that the missed medications for the resident and the discontinued medication for the other resident should have been disposed of according to policy.

The licensee failed to ensure the "Resident Rights, Care and Services - Medication Management - Administration of Medications Policy Version 3", the "Resident Rights, Care and Services - Medication Management - Drug Disposal and Wasting of Medications and Wasting of Medications" policy", the "Safe Storage of Medication Policy 5.1."and the "Disposal of Non-Controlled Medications Policy 5.6." was complied with.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. There is a compliance history of this legislation being issued in the home on February 7, 2017 as an immediate Compliance Order #901 during Critical Incident inspection #2016_254610_0033.

There was also a previous history of non-compliance related to the following:
• O. Reg. 79/10, s. 129 issued on April 2, 2014 as a Written Notification (WN),
• O. Reg. 79/10, s. 131 (3) issued on January 24, 2014 as a WN and Voluntary Plan of Correction (VPC), and
• O. Reg. 79/10, s. 8 (1) (b) issued on February 9, 2016, February 3, 2015, April 16, 2015, and May 24, 2014 as a WN and VPC. [s. 114. (1)]

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. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for the resident that set out the planned care for the resident; the goals the care was intended to achieve; and clear directions to staff and others who provide direct care to the resident.

1) During Stage "1" of the Resident Quality Inspection (RQI), a resident was observed with two specific potential restraints in place.

The current care plan in PointClickCare (PCC) does not set out the planned care related to the use of the specific potential restraint in place; the goals the care was intended to achieve were absent; and there were no clear directions to staff and others who provided direct care to the resident.

The progress notes in PCC documented that the resident used the specific potential restraint since admission. The Restorative Care Coordinator documented the resident was currently awaiting Occupational Therapy (OT) assessment for the specific potential restraint in place.

The Restorative Care/Physiotherapy Referral completed in PCC stated the resident was currently awaiting Occupational Therapy (OT) assessment for the specific potential restraint in place.

Record review of the "Tasks" in PCC had no documentation related to the use or monitoring of the specific potential restraint.

The resident was observed on multiple occasions using the specific potential restraint.

The resident shared that the staff use the specific potential restraint.

The Personal Support Worker (PSW) shared that the specific potential restraint was not a part of the resident's care plan or kardex and that there were no interventions related to the use of the specific potential restraint and the specific potential restraint was not documented by PSWs in Point of Care (POC).

The Administrator and Registered Nurse (RN) verified that the resident used a specific potential restraint and acknowledged that it was not a part of the care plan and was not being monitored in POC. The Administrator and RN both acknowledged that the specific potential restraint and individualized interventions related to this device should be in the care plan for the resident. The plan of care did not have goals the device was intended to achieve and there were no clear directions to staff and others who provided direct care to the resident.

The licensee failed to ensure that there was a written plan of care for the resident that set out the planned care for the use of the specific potential restraint, the goals the care was intended to achieve, and clear directions to staff and others who provided direct care to the resident.

2) During Stage "1" of the RQI, a resident was observed using a potential restraint device in use. The resident also reported that there were no choices related to the type of bath offered and that they were not given the assistance necessary to maintain effective oral hygiene.

A) The resident was observed on multiple occasions with the specific potential restraint in use.

The resident shared that the staff use the specific potential restraint according to the resident's preference.

The current care plan in PCC does not set out the planned care related to the use of the specific potential restraint; the goals the care was intended to achieve were absent; and there were no clear directions to staff and others who provided direct care to the resident.

The "Occupational Therapy" (OT) progress notes documented the following over the course of several months related to the use of the specific potential restraint:
- Resident gave verbal consent to proceed with Assistive Devices Program (ADP)

process for the specific potential restraint.
- Resident started using the specific potential restraint and specific OT instructions were provided.
- Resident using the specific potential restraint with an updated OT instruction provided.

B) The resident shared that the staff only provide a specific type of bath and shared that the staff do not clean the resident's teeth.

Two Personal Support Workers (PSW) shared that staff use a specific oral hygiene product to clean the resident's mouth and teeth. The PSWs stated that the resident wanted the specific potential restraint in place. The PSWs verified that the specific potential restraint was not a part of the interventions in the kardex and should be. The PSWs shared that PSW staff document in Point of Care (POC) the use of the specific potential restraint and the repositioning of any resident who used a specific potential restraint. The PSWs shared that care was provided for personal hygiene and bathing and acknowledged that interventions related to bathing, personal hygiene and the use of a specific oral hygiene product to provide oral care were absent from the plan of care in the kardex and should be there as part of the kardex for PSWs.

The current care plan in PCC related to oral hygiene did not have clear direction to staff related to the use of a specific oral hygiene product to clean the resident's mouth and teeth and there were no goals or interventions related to bathing or personal hygiene in the resident's care plan.

The most recent Minimum Data Set (MDS) Assessment completed in PCC documented that the resident required staff assistance for bathing, personal hygiene, locomotion and mobility.

The Administrator and the RN verified that the resident used the specific potential restraint and acknowledged that the device was not part of the care plan and was not being monitored in POC. The RN also acknowledged that the bathing activity was not part of the planned care for the resident, that there were no goals or interventions related to personal hygiene and there were no specific interventions related to the use of a specific oral hygiene product to clean the resident's mouth and teeth. The Administrator and the RN acknowledged that bathing, personal hygiene and the specific potential restraint required individualized interventions and should be in the care plan for the resident.

The licensee failed to ensure that there was a written plan of care for the resident that set out the planned care for the use of a specific potential restraint, bathing and personal and oral hygiene; the goals the care was intended to achieve; and clear directions to staff and others who provide direct care to the resident.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There is a compliance history of this legislation being issued in the home on April 16, 2015 as a Voluntary Plan of Correction (VPC) during the Resident Quality Inspection (RQI) #2015_418615_0003, on February 9, 2016 as a VPC during the RQI # 2016_457630_0003 and on July 5, 2016 for Complaint inspection #2016_457630_0026. [s. 6. (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 there is a written plan of care for the resident that set out the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

The home's policy titled "Continence Care and Bowel Management Program" last revised July 24, 2014, stated: "Registered staff shall ensure that: referrals and additional "assessments for continence" is completed with any decline in bowel and/or bladder continence indicated in completing RAI-MDS."

A) The Minimum Data Set (MDS) assessment documented that a resident had a decline in their level of continence for both bladder and bowel from the previous MDS assessment.

Review of the clinical record in PointClickCare (PCC) for the resident included a progress note indicating worsened bowel and bladder continence. This note also stated that Personal Support Workers stated that the continence level of this resident had declined. Interventions were noted to be added to the care plan for this resident as a result of the noted decline in continence. Review of the care plan for the resident noted the suggested interventions had been included in the care plan for this resident.

The Director of Care stated that in addition to the high risk rounds assessment and decisions required interventions, an "assessment for continence" should be completed in PCC, and was also indicated in the home's policy. Review of PCC included an "assessment for continence" on admission, but did not include any further assessments for continence. The Director of Care stated that the resident had not been assessed for incontinence using a clinically appropriate assessment instrument that was designed for assessment of incontinence.

B) The Minimum Data Set (MDS) assessment documented that a resident had a decline in their level of continence for bladder from the previous MDS assessment.

Review of the clinical record in PCC for the resident included a progress note which stated that the resident had worsened bladder continence and that the resident refused interventions for toileting to promote continence.

The Director of Care stated that the resident had not been assessed for incontinence using a clinically appropriate assessment instrument that was designed for assessment

of incontinence.

The licensee has failed to ensure that both residents who were incontinent received an assessment that was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. There is no compliance history of this legislation being issued in the home in the past three years. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who is incontinent received an assessment that is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident required, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the Residents' Council advised the licensee of concerns or recommendations, they responded to the Residents' Council in writing within 10 days of receiving the advice.

The resident told the Inspector that they were an active member of the home's Residents' Council. The resident said that the Residents' Council members had raised various concerns and recommendations during the meetings in April, May and June 2017. When asked how the home responded to the concerns raised by the Resident's Council during the meetings, the resident said they did not think they had received written responses to the concerns. The resident said they thought some of the concerns raised by the Residents' Council had not been resolved, such as the condition of the couch in a particular home care area and staff conversations in the hallways early in the mornings.

Review of the home's Residents' Council Minutes for April to June 2017 showed that there were concerns raised and documented with no associated written response in the meeting minutes or the Administrator's Report in the posted Residents' Council Binder. For example the following concerns had no written responses within 10 days:
- The meeting minutes for April 11, 2017, showed the concern that the lounge couch was dirty and had an odour. It stated that "residents would like it removed and two chairs placed there."
- The meeting minutes for April 11, 2017, showed the concern that "bedding changes are not happening on a regular basis."
- The meeting minutes for May 9, 2017, showed the concern with the "conversations happening in the hallway in the evening and it is waking up people in private rooms" and "still conversation at 0630 hours during report laughing and talking."

The Life Enrichment Coordinator (LEC) and Administrator told the Inspector that the concerns and recommendations raised by the Residents' Council were documented in the meeting minutes. They said that individual resident concerns raised during the meetings were documented and addressed using the home's internal complaint process while concerns raised regarding larger issues affecting residents in the home were addressed verbally by the management at the time and then reviewed at the next council meeting.

The Inspector reviewed the Residents' Council Minutes for April to June 2017 with the LEC and the Administrator and they acknowledged the management in the home had not provided the Residents' Council with a written response to the concerns within 10 days of receiving the advice.The Administrator said they were unaware that the home needed to respond to the Residents' Council in writing within 10 days and planned to review their process to ensure that they were meeting the legislative requirements.

The licensee failed to ensure to respond in writing within 10 days when the Residents' Council advised the licensee of concerns or recommendations.

The severity was determined to be a level 1 as there was minimal risk. The scope of this issue was widespread during the course of this inspection. There is no compliance history of this legislation being issued in the home in the past three years. [s. 57. (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 when the Residents' Council advised the licensee of concerns or recommendations they respond to the Residents' Council in writing within 10 days of receiving the advice, to be implemented voluntarily.

Issued on this 2nd day of November, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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) :	MELANIE NORTHEY (563), AMIE GIBBS-WARD (630), NANCY SINCLAIR (537), NEIL KIKUTA (658)
Inspection No. / No de l'inspection :	2017_606563_0014
Log No. / No de registre :	013220-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 6, 2017
Licensee / Titulaire de permis :	MEADOW PARK (LONDON) INC 689 YONGE STREET, MIDLAND, ON, L4R-2E1
LTC Home / Foyer de SLD :	MEADOW PARK (LONDON) INC. 1210 SOUTHDALE ROAD EAST, LONDON, ON, N6E-1B4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Nicole Ross

To MEADOW PARK (LONDON) INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_419658_0015, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee will ensure compliance with O. Reg. 79/10, s. 50 (2) by ensuring that all residents who exhibit altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds are appropriately assessed.

The licensee must initiate steps towards protecting residents who exhibit or develop altered skin integrity while in the care of the long-term care home. This includes, but is not limited to:
- Assessing residents as required for any altered skin integrity using a clinically appropriate assessment instrument specifically designed for skin and wound assessment that reflects the tools identified in the skin and wound program in the home;
- Referring all residents who exhibit altered skin integrity to a registered dietitian who will then conduct an assessment, and implement any changes made to the resident's plan of care relating to nutrition and hydration;
- Ensuring residents who exhibit altered skin integrity are reassessed at least weekly by a member of the registered nursing staff; and
- Ensuring that implemented interventions for all residents exhibiting altered skin integrity are monitored and evaluated appropriately.

The licensee will also ensure that all registered staff are educated on the home's skin and wound program.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin assessment.

The licensee has failed to comply with Order #001, Complaint Inspection #2016_419658_0015, with a compliance date of June 30, 2017 related to ensuring that all registered staff were re-educated on the home's skin program.

Ontario Regulation 79/10, s. 50(3) defines altered skin integrity as the potential or actual disruption of epidermal or dermal tissue.

A) A resident was observed with a dressing in place. The Registered Practical Nurse (RPN) verified that the resident had an area of altered skin integrity and a treatment plan was in place.

Record review of online progress notes documented in PointClickCare (PCC) stated that the resident had a physician's order for treatment to the area of altered skin integrity.

The Staff Educator said that they were the skin and wound lead for the home and explained that registered staff were required to complete a skin assessment under the assessments tab in PCC, as well as a progress note for any area of altered skin integrity. Record review showed that a skin assessment and progress note were not completed for the resident.

The Staff Educator acknowledged that a skin assessment was not completed for the resident and that an assessment was required to be completed for all area of altered skin integrity. The Staff Educator also acknowledged that education related to Order #001 was not provided to all registered staff in the home, and that the entire skin and wound program developed by the home was not re-educated to registered staff by the compliance date of June 30, 2017.

The licensee has failed to ensure that altered skin integrity, including skin breakdown, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

B) A resident sustained an injury that required a dressing to a wound.The progress notes in PointClickCare (PCC) stated that a dressing was changed.

Record review showed that a skin assessment and progress note were completed that identified an area of altered skin integrity.

The Staff Educator explained that registered staff were expected to immediately complete an assessment for residents with altered skin integrity and acknowledged that a skin assessment and progress note were not completed until several days after the resident sustained an injury that required a dressing.

The licensee failed to ensure that the resident's area of altered skin integrity received a skin assessment by a registered staff member. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin tears, was assessed by a registered dietitian.

Record review of progress notes in PointClickCare (PCC) showed that the resident developed an area of altered skin integrity. A progress note was completed by the Registered Practical Nurse (RPN). The assessment identified that the skin care co-ordinator and physician were notified, but that a dietary referral was not completed.

The RPN stated that they had not sent a referral for the resident's altered skin integrity, and would only complete a referral to the Registered Dietitian (RD) when the area of altered skin integrity did not improve or worsened.

The RD explained that any impediment of skin integrity should be referred to and assessed by the RD and told the inspector that a referral was not completed for the resident's altered skin integrity.

The licensee failed to ensure that a dietary referral and RD assessment was completed related to the resident's altered skin integrity.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. There is a compliance history of this legislation being issued in the home on April 2, 2015 as a Written Notification during Critical Incident Inspection #2015_416515_0009 and on May 25, 2017 as Compliance Order #001 during Complaint inspection #2016_419658_0015. [s. 50. (2) (b) (iii)] (658)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

Order / Ordre :

To achieve compliance with O. Reg. 79/10, s. 114 (1), the licensee shall develop an interdisciplinary medication management system that provides safe medication management.
Specifically, the licensee will:

1. Develop a procedure to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. Evaluate the implementation of the procedure to ensure medications from properly labelled vials, packages, strip pouches, and blister packs dispensed from the home's pharmacy service provider are administered.

2. 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.

3. Implement a system identifying who is responsible for completing the monthly audits of the daily count sheets for controlled substances and ensure the persons responsible receive direction related to the use of the audit. Also, identify when the audits are to be completed and the time frames of the audits are to be clearly documented. Evaluate the information gathered through the monthly audits to determine if there are any discrepancies and take immediate action if any discrepancies are discovered. Document the actions taken.

4. Implement a system for establishing accurate and up-to-date drug records that include the following information for every drug ordered and received in the

home:
a) The date the drug is ordered
b) The signature of the person placing the order
c) The name, strength and quantity of the drug
d) The name of the place from which the drug is ordered
e) The name of the resident for whom the drug is prescribed, where applicable
f) The prescription number, where applicable
g) The date the drug is received in the home
h) The signature of the person acknowledging receipt of the drug on behalf of the home
Maintain and keep a drug record for every drug that was ordered and received in the home within the home for at least two years.

5. Develop and implement a system to ensure that for medication incidents and adverse drug reactions:
a) Every medication incident and adverse drug reaction will be documented with a record of the immediate and corrective actions taken to maintain the resident's health.
b) Every medication incident and adverse drug reaction will be reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.
c) All medication incidents and adverse drug reactions are documented, reviewed and analyzed; corrective action will be taken as necessary and a written record kept of this.
d) Medication incidents and adverse drug reactions will be reviewed and analyzed quarterly in order to reduce and prevent medication incidents and adverse drug reactions; and a record kept of everything.

6. Ensure that medication policies that are required by the Long-Term Care Homes Act, 2007 or O.Reg. 79/10, are complied with.

Grounds / Motifs :

1. The licensee of the long-term care home failed to develop an interdisciplinary medication management system that provided safe medication management, as evidenced by:

1. The licensee failed to comply with O. Reg. 79/10, s.126, by failing to ensure

that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

2. The licensee failed to comply with O. Reg. 79/10, s 129 (1) (b), by failing to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

3. The licensee failed to comply with O. Reg. 79/10, s. 130 (3), by failing to ensure that a monthly audit was undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies, and that immediate action was taken if any discrepancies were discovered.

4. The licensee failed to comply with O. Reg. 79/10, s. 133, by failing to ensure that a drug record was established, maintained and kept in the home for at least two years, in which was recorded the following information in respect of every drug that was ordered and received in the home:
1. The date the drug was ordered
2. The signature of the person placing the order
3. The name, strength and quantity of the drug
4. The name of the place from which the drug was ordered
5. The name of the resident for whom the drug was prescribed, where applicable
6. The prescription number, where applicable
7. The date the drug was received in the home
8. The signature of the person acknowledging receipt of the drug on behalf of the home
9. Where applicable, the information required under subsection 136(4).

5. The licensee failed to comply with O. Reg. 79/10, s. 135, by failing to ensure that every medication incident involving a resident and every adverse drug reaction was:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.
In addition, the licensee failed to ensure that,

(a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed;
(b) corrective action was taken as necessary; and
(c) a written record was kept of everything.
The licensee failed to ensure that,
(a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions;
(b) any changes and improvements identified in the review were implemented; and
(c) a written record was kept of everything.

6. The licensee failed to comply with O. Reg. 79/10, s. 8 (1) (b), by failing to ensure that a plan, policy, protocol, procedure, strategy or system that is required by the Long-Term Care Homes Act, 2007 or O. Reg. 79/10, was complied with.

Inspectors reviewed the licensee's current policies, the policies and procedures of Silver Fox Pharmacy, the drug records related to ordering and receiving medication, the monthly audits of controlled substance shift counts, the monthly audits completed by Silver Fox Pharmacy, the Medication Incident Notices/Forms, the education and training materials presented by Silver Fox Pharmacy, and the Electronic Medication Administration Records (eMAR). Inspector(s) interviewed staff of the licensee and representatives of the pharmacy service provider, Silver Fox Pharmacy. Inspectors completed observations of the medication rooms, medication carts, medication refrigerators, emergency medication supply, medication administration, and the drug destruction of controlled substances and non-controlled substances. Record reviews, interviews and observations identified non-compliance with the following requirements.

1. To achieve compliance with O. Reg. 79/10, s. 114 (1), the licensee was to develop an interdisciplinary medication management system that provided safe medication management. As part of Compliance Order (CO) #901 issued during Critical Incident (CI) inspection #2016_254610_0033, the licensee was required to educate all registered staff regarding the policy and procedures for unused or wasted medication for storage, and implement the procedure on administering medications from properly labelled vials, packages, strip pouches, and blister packs dispensed from the home's pharmacy service provider.

The licensee failed to comply with O. Reg. 79/10, s. 126, by failing to ensure that drugs remained in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

The Silver Fox Pharmacy Policy and Procedure Educational Session by PowerPoint was presented to all registered staff in March 2017 with respect to safe storage of medication. The registered staff were instructed that all medication should remain in their original Silver Fox Pharmacy labelled container until they were administered to an individual. Unused or wasted medication should be stored separately from active medication in a locked area until destruction.

The "Resident Rights, Care and Services - Medication Management - Administration of Medications Policy Version 3" revised July 20, 2017 stated that at the time of medication administration, the registrant will ensure that the medication was properly packaged and labeled and would administer medications only from properly labelled files, packages, strip pouches, blister packs dispensed from pharmacy, and/or properly labelled government stock pharmaceuticals.

The “Safe Storage of Medication Policy 5.1.” dated June 2016 stated all medication should remain in their original Silver Fox labelled container until they were administered to an individual.

The "Resident Rights, Care and Services - Medication Management - Drug Storage" policy with a revised date of October 7, 2013 (2013-10-07) stated the registered staff members administering medications would ensure that all drawers and bins of the medication cart were properly labelled as applicable and that discontinued or outdated medications were removed immediately from the medication cart, refrigerator, or government stock cupboards.

The “Medications Systems Audit” for an identified home care area was completed by the Silver Fox Pharmacy Director of Projects and Innovation (DPI). The audit stated, "Ensure medication capsules are kept in the original pharmacy labelled box. Most eye drops and medication cartridges are labelled with date opened however found some not labelled." An audit was also completed by the DPI for another home care area and documented that drugs were not stored in

the original packaging.

Inspectors observed the medication cart and noted the following:
• In a marked container, medication capsules were not in the original labelled package, but the labelled portion of the package was ripped off and placed in the marked container,
• Blue coloured inhaler with no pharmacy label, but had paper tape covering the outside of the inhaler with a hand written label of a resident's name,
• Unlabelled eye drops, and
• Top drawer of the medication cart had one round white tablet and an oblong pink speckled tablet outside of the original packaging and sitting loose among other medication supplies.

The RPN and RN could not identify which resident the two loose tablets in the top drawer of the medication cart belonged to. The RN suspected it might be from the emergency stock. Both registered staff acknowledged that all medications were to remain in the original labelled container or package provided by the pharmacy.

Inspectors observed the medication cart and noted one medication container with a specific Drug Identification Number (DIN) and prescription number (Rx) from “Emergency Supply” with a handwritten label in blue pen with a resident's name.

The RPN acknowledged that the medication pen for the resident was illegible, and verified that there was no name on the medication pen, only a hand written name on the box.

Inspectors observed another medication cart and noted the following:
• In a marked container, medication capsules were not in the original labelled pharmacy package,
• Outside a marked container, a pre-filled syringe was unlabelled and outside of the original labelled package located in another drawer,
• In an unmarked container, medication capsules were not in the original labelled package and sitting beside an inhaler,
• Medication pen container and the medication pen for a resident were not labelled with an original label from pharmacy, and
• Medication patches in a box with no pharmacy label and a handwritten label with the name of a resident.

The RN acknowledged that the label for the medication pen was a label that came from the resident's chart and was not the original label from pharmacy. As for the medication patches, the RPN verified that there was a physician's order and the patches were not labelled with an original label from pharmacy.

Inspectors observed another medication cart and noted the following:
• In a marked container, medication capsules were not in the original labelled package,
• In an unmarked container, medication capsules were not in the original labelled package and sitting beside an inhaler,
• One bottle of medication syrup did not have an original pharmacy label, and the last name of a resident was handwritten on the front of the bottle, and
• In an unmarked container in the fifth drawer, there was one unlabelled medication puffer and one medication patch located outside of the original labelled package from pharmacy with a handwritten label that documented a resident's first name.

The RN acknowledged that the Ventolin puffer was unlabelled and was unsure who the puffer belonged to. The RN also explained that the unlabelled box in the fifth drawer with various medications was a box that contained medications for destruction.

The Staff Educator verified that all medications should be in their original labelled pharmacy package.

The licensee failed to ensure that drugs remained in the original labelled container or package provided by the Silver Fox Pharmacy service provider until the medications were administered to a resident or destroyed.

2. To achieve compliance with O. Reg. 79/10, s. 114 (1), the licensee was to develop an interdisciplinary medication management system that provided safe medication management. As part of CO #901 issued during CI inspection #2016_254610_0033, the licensee was required to educate and train all registered staff on safe storage of controlled substances in double locked storage areas or in a separate locked area within the locked medication cart.

The licensee failed to comply with O. Reg. 79/10, s. 129 (1) (b), by failing to ensure that controlled substances were stored in a separate, double-locked

stationary cupboard in the locked area.

The Silver Fox Pharmacy Policy and Procedure Educational Session by PowerPoint was presented to all registered staff in March 2017 with respect to the safe storage of medication. Controlled substances must be stored separately in a double locked area and the location of the emergency controlled substances may be within a medication cart or in the "stat box" located in the home in a locked medication room.

The “Emergency Medication Home Supply Policy 3.10.” dated June 2016 stated, "if controlled substances are included in the emergency medication home supply, storage in a locked and secure area will be determined by the home."

Inspectors observed a specific medication room and noted that inside one of the refrigerators contained a locked black box. The RN unlocked the black box in the fridge and there was an injectable controlled substance inside. Inspectors reviewed the finding with the Staff Educator and the Director of Care (DOC). The DOC acknowledged that the controlled substance should be stored in a separate, double-locked stationary cupboard and that the black box was not stationary.

The Staff Educator acknowledged that the locked black metal boxes in the refrigerators in each home care area would contain controlled substances, but that not all boxes necessarily have a controlled substance in them. All home care area medication room refrigerators were observed and only one medication refrigerator had a controlled substance contained in the black locked box.

An email titled “lock boxes” from the Silver Fox Pharmacy Director of Projects and Innovation to the Staff Educator stated, "there is nothing in the act other than it needs to be double locked which it is" “keeping it in the lock box in the fridge in a locked med room should be sufficient."

The "Resident Rights, Care and Services - Medication Management -Narcotics and Controlled Substances" policy with a revised date of October 7, 2013 (2013-10-07) stated all narcotics shall be stored in a permanently affixed cabinet, under double lock at all times accessible only by a registered staff member.

The "Resident Rights, Care and Services - Medication Management - Drug Storage" policy with a revised date of October 7, 2013 (2013-10-07) stated the

Director of Care would ensure that medications were stored and secured in keeping with the legislation. The registered staff members administering medications would ensure that all narcotics were stored in a double locked, permanently affixed compartment within the general medication cart and or medication room.

The licensee failed to ensure that the injectable controlled substance was stored in a separate, double-locked stationary cupboard in the locked area.

3. To achieve compliance with O. Reg. 79/10, s. 114 (1), the licensee was to develop an interdisciplinary medication management system that provided safe medication management. As part of CO #901 issued during CI inspection #2016_254610_0033, the licensee was required to conduct monthly audits of the daily count sheets for controlled substances, evaluate the information gathered through the monthly audits to determine if there were any discrepancies and take immediate action if any discrepancies were discovered. The actions taken were to be documented.

The licensee failed to comply with O. Reg. 79/10, s. 130 (3), by failing to ensure that a monthly audit was undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies, and that immediate action was taken if any discrepancies were discovered.

The Silver Fox Pharmacy Policy and Procedure Educational Session by PowerPoint was presented to all registered staff in March 2017 with respect to controlled substance documentation and that the home must complete a monthly audit of the daily controlled substance count sheets and to immediately report any discrepancies to the Director of Care.

The Staff Educator shared that the medication audits were completed once a month. The Staff Educator, the Director of Care (DOC) and the Resident Assessment Instrument Coordinator (RAI-C) visited each nursing station and completed the audit and it was the same audit that pharmacy used. The Staff Educator stated that each drug record book, medication cart, and treatment cart was audited and that this was documented as part of the audit. Inspector asked what the process was if there was a discrepancy in the drug record and the Staff Educator shared that there would be follow up with the registered staff involved. Also, daily narcotic count sheets were audited monthly and the home had created an additional controlled substances audit to encourage nurses to do it

themselves once a month before management audits.

The "Controlled Substance Process Audit" referenced O. Reg. 79/10, s. 130 where the daily count sheets of controlled substances were to be audited monthly to identify any potential discrepancies and take immediate action. The "Controlled Substance Shift Count" process was to audit that two signatures were present at each shift count and that the shift count matches the administration record. The following was documented as part of this audit for the following months in the following home care areas:

April 2017:
• An identified home area: Staff Educator and the RAI-C completed the audit where the controlled substance shift count had one missing entry and was flagged for follow up.
• Another identified home area Staff Educator and the RAI-C completed the audit where there was one missing signature on the Individual and Shift Count sheets and flagged for follow up.

May 2017:
• All four home areas were not completed

June 2017:
• Two home areas were not completed

July 2017: as of July 28, 2017
• All four home areas were not completed

The “Medication Systems Audit” was also to be completed monthly for each home care area which identified whether an audit of the daily count sheets of controlled substances was performed monthly by the home. All Medication System Audits completed in April, May, June and July 2017 identified with a “Y” for yes that an audit was completed. However, there was no documented evidence of a controlled shift or individual count audit for all home care areas for May, or for two home care areas in June and although the medication system audits for July documented that the daily count sheets were audited, there was no documented evidence that this occurred.

The “Controlled Substance Documentation Policy 5.3.” dated June 2016 stated an audit of the daily controlled substance count sheet was to be completed by

the staff at the home on a monthly basis and all discrepancies must be reported immediately to the Director of Care.

The Staff Educator shared that the registered nursing staff did not receive instruction on how to complete or when to complete the audit tools and acknowledged that the "Controlled Substance Process Audit" did not identify an audit time-frame. The Inspector asked where corrective action was documented in the audits and who was responsible for the follow up and the Staff Educator did not know. The Staff Educator also verified that the "Controlled Substance Process Audits" were not being completed monthly for each home care area.

The RAI-C also acknowledged that registered staff were not instructed on how to complete the audit tools and that the registered staff were to let them know right away if there was a discrepancy during any narcotic counts.

The Staff Educator and Inspector reviewed "Controlled Substance Process Audit" for one home care area where the "Shift Count" was marked "Y" for "yes" indicating that the shift count had two signatures present at each shift count. The Staff Educator could not verify the time period of this audit, and acknowledged that the registered staff did not receive directions related to the use of the form except that they were to work through it. The Staff Educator thought that the form may be just for the day indicated and not an audit for the month as required. The Inspector reviewed the "Medications System Audit" completed by the DOC for a home care area where under the "Documentation" heading "Y" for yes was answered that "an audit of the daily count sheets of controlled substances is performed monthly by the home". There were no comments documented related to any discrepancies noted. The Inspector reviewed the "Controlled Substance Shift Count" for a particular home care area for a missing signature on the evening shift for the incoming registered staff member. The Staff Educator acknowledged that shift count required two registered staff signatures at each shift count every day and that the Medication System Audit did not document the discrepancy identified.

The “Controlled Substance Shift Counts” completed for all four home care areas had missing signatures of the registered staff for both the incoming and outgoing staff member on multiple days. The records were missing for one particular home care area. The DOC acknowledged that the controlled substance shift counts were missing for one week for one home care area.

The DOC was shown inconsistencies in audit completion and documentation. The DOC acknowledged that the "Controlled Substance Process Audit" does not identify a time-frame the daily count sheets for controlled substances were reviewed. The DOC also verified that the controlled substance process audits were not completed for May 2017 and only completed for two home care areas in June 2017. Inconsistencies among controlled substance process audits for daily shift counts and medication systems audits were reviewed. The DOC acknowledged inconsistencies and that audits completed in the home were not matching the information in the daily shift counts. The documentation as part of the controlled substance process audits was not capturing the actual discrepancies identified by the Inspectors during the record review of the shift count sheets. The DOC shared that there would be follow up with the registered staff related to missing signatures identified on the controlled substance shift count sheets, but acknowledged that as part of the June audit, there was no follow up with the evening registered staff member. The DOC also acknowledged that there was no documented follow up related to the actions taken for the missing signatures identified on the April 2017 "Controlled Substance Shift Count" audit of the individual and shift daily count sheets.

The licensee failed to ensure that a monthly audit was undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies, and that immediate action was taken if any discrepancies were discovered.

4. To achieve compliance with O. Reg. 79/10, s. 114 (1), the licensee was to develop an interdisciplinary medication management system that provided safe medication management. As part of CO #901 issued during CI inspection #2016_254610_0033, the licensee was required to educate and train all registered staff regarding the policy and procedure for maintaining a drug record. Also, to implement a system for establishing accurate and up-to-date drug records that included the information as described in s. 133 for every drug that was ordered and received in the home.

The licensee failed to comply with O. Reg. 79/10, s. 133, by failing to ensure that a drug record was established, maintained and kept in the home for at least two years, which recorded the following information, in respect of every drug that was ordered and received in the home:
1. The date the drug was ordered
2. The signature of the person placing the order

3. The name, strength and quantity of the drug
4. The name of the place from which the drug was ordered
5. The name of the resident for whom the drug was prescribed, where applicable
6. The prescription number, where applicable
7. The date the drug was received in the home
8. The signature of the person acknowledging receipt of the drug on behalf of the home
9. Where applicable, the information required under subsection 136(4).

The Silver Fox Pharmacy Policy and Procedure Educational Session by PowerPoint was presented to all registered staff in March 2017 with respect to the drug record. All medications received at the home must be documented in the drug record. If procedure has been followed correctly all receiving information will be accompanied by ordering details. The legislation r. 133 was reviewed with the following information with respect to every drug that was ordered and received in the home. It was reviewed that the drug record should be stored in the home for a minimum of two years. The training included a review of how to complete the drug record form for ordering new medications and that it was completed by the ordering nurse and completed by the receiving nurse.

The “Ordering Prescriptions Policy 3.2.” dated June 2016 stated registered staff were to enter the prescription information into the appropriate boxes on the drug record page or peel the reorder label from the desired medication and place it in the drug record in the next available space. Initial and date in the appropriate boxes and repeat this process for all items re-ordered.

The “Drug Record Policy 3.3.” dated June 2016 stated the drug record should be stored in the home for a minimum of two years. Once the new or repeated medication has been received at the home, the person checking it will sign and date, record the new prescription number and the quantity received. Any staff member may now check the "Drug Record" to verify that the medication has been received within the home.

The "Resident Rights, Care and Services - Medication Management - Narcotics and Controlled Substances" policy with a revised date of October 7, 2013 (2013-10-07) stated a count of narcotics shall be completed by the off going and incoming registered staff member at change of shift and whenever an exchange of medication keys takes place.

The Staff Educator shared that there was a lot of time spent reviewing the drug records during the PowerPoint education session and the home was auditing each drug record book and if there was a discrepancy in the drug record, there would be follow up with the registered staff involved. The Staff Educator also shared that drug records were given to the Director of Care (DOC) and kept in the DOC office.

The narcotic and controlled substance destruction was observed with the Consultant Pharmacist (CP) and the Registered Nurse (RN) in attendance. The CP shared that the original individual administration record should be kept in the home for two years and once the narcotic destruction has been completed, the original records were given to the DOC/Administrator.

The "Drug Records" dated June 1 to 30, 2017 in every home care area was missing information documented for drugs ordered and received in the home:
• One home care area had missing information for approximately 70% of medications ordered and received,
• One home care area had missing information for approximately 50% of medications ordered and received,
• One home care area had missing information for approximately 55% of medications ordered and received, and
• One home care area had missing information for approximately 65% of medications ordered and received.

The Staff Educator and the Inspector reviewed the drug record where the resident's specific medication was documented as ordered with no prescription number or quantity indicated. Reviewed the drug record where another resident's medication was documented as ordered with no prescription number or quantity indicated. The Staff Educator acknowledged mandatory information was missing.

The Medications Systems Audit was completed by the Silver Fox Pharmacy Director of Projects and Innovation where the audit documented "N" for "no" for "the drug record was readily available and maintained" with a comment which stated the drug record was missing several entries by both the ordering and receiving nurse in April, May and July for three of four home areas.

During a telephone interview, the Director of Projects and Innovation, the Chief

Operating Officer, and the Pharmacy Manager reviewed the Medication Systems Audit shared that the drug records reviewed as part of this audit would be for the time period of one month.

The "Medication Systems Audit" was completed by the RAI-C for each home care in July 2017. Two home care area audits were completed with an identified discrepancy related to a small number of missing signatures on the drug record.

The Director of Care (DOC) acknowledged that there were multiple areas of missing documentation for both ordering and receiving of medications on the drug records for all four home care areas. The DOC verified that the drug records were not maintained.

The licensee failed to ensure that the drug records were maintained and recorded the information required in s. 133 for every drug that was ordered and received in the home.

5. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

In addition, the licensee failed to ensure that,
(a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed;
(b) corrective action was taken as necessary; and
(c) a written record was kept of everything.

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

The Silver Fox Pharmacy Policy and Procedure Educational Session by PowerPoint was presented to all registered staff in March 2017 with respect to medication incidents. The training materials described a medication incident as a preventable event associated with the prescribing, ordering, dispensing, storing, labeling, administering or distributing of a drug, or the transcribing of the prescription, and included an active omission or commission, whether or not it resulted in harm, injury or death to a resident or a near miss event where the incident does not reach a resident but had it done so, harm, injury or death could have resulted. Registered staff reviewed common medication incident types, reporting requirements, quality improvement, investigation, and appropriate and immediate actions taken. Registered staff also reviewed the documentation requirements for the medication incident form.

The "Resident Rights, Care and Services - Medication Management - Medication Incident Policy Version 2" revised July 20, 2017, stated a medication incident shall be defined as a preventable event associated with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a prescription. Upon identification of a medication error, the individual identifying the error would assess the resident for any signs or symptoms of reaction to the error, notify the physician, the resident and the resident's SDM, report the incident to the attending physician, Director of Care (DOC), pharmacist; then initiate and complete the internal medication incident report and forward the completed report to the DOC, physician and pharmacist and document in the progress notes the status of the resident, actions taken and further follow up action required.

The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. In addition, the licensee failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analysed; corrective action was taken as necessary; and a written record was kept of everything.

A "Medication Incident Notice" was completed for a resident. The incident form

did not identify the staff member who made the medication error, or the staff member who identified the error. Multiple medications were charted as given at 0800 hours, but the unopened medication package for 0800 hours was found in the medication cart at bedtime. The incident form documented that the event was communicated to "resident/Power of Attorney (POA)", "Silver Fox Pharmacy", "On call" prescriber and the "DOC". The DOC acknowledged that the RPN was responsible for the dose omission, and that there was no corrective action for the RPN documented. During a telephone interview, the Inspector reviewed the medication incident with the Silver Fox Pharmacy Director of Projects and Innovation, the Chief Operating Officer, and the Pharmacy Manager and they verified that the incident was not faxed to pharmacy. The Silver Fox Pharmacy Chief Operating Officer shared that the pharmacy was to receive all medication incidents, especially an omission.

A "Medication Incident Form" was completed for a resident. The form documented that a medication for noon was missed. Incident type was documented as "dose omission". The incident form was signed by the DOC. The DOC verified that follow up with the staff member depended on the seriousness of the medication incident and the staff would be called immediately or they would wait until the staff member's next scheduled shift. The DOC verified that follow up with the Registered Practical Nurse (RPN) did not occur and acknowledged that there should always be a follow up with the staff member. The RPN Schedule documented that there were four scheduled shifts between Monday and Friday where the DOC could have followed up with the RPN and did not.

A "Medication Incident Notice" was completed for a resident. The medication was described with just the name and no other description documented. The outcome of the incident was left blank. The RPN reported the narcotic count sheet was missing from the narcotic ampules. RN took the narcotic count sheet home and returned the form to the resident's chart. The RPN and the RN did not complete the daily count sheet. The DOC verified that the medication incident notice lacked the appropriate documentation and was left incomplete. During a telephone interview, the Inspector reviewed the medication incident with the Silver Fox Pharmacy Director of Projects and Innovation, the Chief Operating Officer, and the Pharmacy Manager and they verified that the Medication Incident Notice completed for the resident was not faxed to pharmacy and they verified that pharmacy would expect notification of this type of error. The Director of Projects and Innovation shared they would like to look at all incidents from a

pharmacy perspective and all incidents were tracked by pharmacy regardless of the origin of the error.

A "Medication Incident Notice" was completed for a resident. A specific medication was discontinued as signed by the Physician. A new batch of medication strips arrived containing the discontinued medication. The DOC acknowledged that the medication incident notice should have been faxed to pharmacy. During a telephone interview, the Inspector reviewed the medication incident with the Silver Fox Pharmacy Director of Projects and Innovation, the Chief Operating Officer, and the Pharmacy Manager and they verified that this incident was not faxed to pharmacy, that pharmacy was faxed the discontinuation of the medication several days later. They shared that the expectation would be for the home to fax the discontinued order on the same day it was discontinued. Review of a copy of the fax verified receipt of the physician's orders to pharmacy was dated several days after the discontinuation of the drug.

A "Medication Incident Notice" was completed for a resident. The Registered Practical Nurse (RPN) administered two tablets instead of the one tablet ordered. Review of the progress notes verified there was no documentation related to the overdose monitoring or assessment of the resident. The DOC acknowledged there was no follow up monitoring or assessment of the resident documented as part of the resident's clinical record. The DOC also verified that there was no follow up with the RPN and nothing documented in the staff member's Human Resource (HR) file. During a telephone interview, the Inspector reviewed the medication incident with the Silver Fox Pharmacy Director of Projects and Innovation, the Chief Operating Officer, and the Pharmacy Manager and they verified that this incident was not faxed to pharmacy and that it should have been faxed for their review.

The Staff Educator shared that the nurse who discovered the medication incident would fill out the form, take action as needed, and fax the form to pharmacy. The original goes to the DOC and the DOC takes corrective action.

The Director of Care (DOC) shared that they were unable to locate the Professional Advisory Committee (PAC) meeting minutes from the last meeting in March or April 2017. The DOC and the Administrator shared that the PAC meeting was pushed from April and scheduled for May 2017. The Administrator verified that the PAC meeting occurred on this date, but that there was no record

of the meeting minutes found. The DOC acknowledged that there were five medication incidents documented in January, one in February and seven medication incident forms completed for March 2017. Both the DOC and Administrator acknowledged that there should be a written record of the quarterly review undertaken of the 13 medication incidents that occurred in the home since the time of the last review.

During a telephone interview, the Inspector reviewed the medication incident with the Silver Fox Pharmacy Director of Projects and Innovation, the Chief Operating Officer, and the Pharmacy Manager shared that although pharmacy reviews each medication incident, that a pharmacy summary would not have been completed unless it was a pharmacy error. All pharmacy errors were analyzed and summarized and the summaries were then faxed to the Administrator and DOC of the home. A quarterly review was to be undertaken of all medication incidents regardless of origin.

The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented with a record of the immediate actions taken to assess and maintain the resident's health. The incidents were not reported to the appropriate persons as described in O. Reg. 79/10, s. 135, corrective action was not taken as necessary and there was not a written record kept of everything. There was no documented evidence of a quarterly review undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review.

6. To achieve compliance with O. Reg. 79/10, s. 114 (1), the licensee was to develop an interdisciplinary medication management system that provided safe medication management. As part of Compliance Order (CO) #901 issued during Critical Incident (CI) inspection #2016_254610_0033, the licensee was required to educate and train all registered staff on the procedure in the home for the recording of the daily count sheets for controlled substances.

The licensee failed to comply with O. Reg. 79/10, s. 8(1)(b), by failing to ensure that the "Controlled Substance Documentation Policy 5.3." that was required by the Long-Term Care Homes Act, 2007 or O. Reg. 79/10, was complied with.

A) The "Controlled Substance Documentation Policy 5.3." dated June 2016 stated counts must be done at every shift change with two staff members on the controlled substance shift count record. Both staff members must be present

and complete the count together. An audit of the daily controlled substance count sheet was to be completed by the staff at the home on a monthly basis and all discrepancies must be reported immediately to the Director of Care.

The Silver Fox Pharmacy Policy and Procedure Educational Session by PowerPoint was presented to all registered staff in March 2017 with respect to controlled substance documentation. Every change of staff required a shift count by two staff members on the controlled substance shift count record. Registered staff reviewed the count sheets as part of their education related to documentation.

One home care area "Controlled Substance Shift Count" had missing registered staff signatures on the day, evening and night shift on multiple dates.

The home care area medication room was observed. The RPN and the RN were present at the shift change controlled substance count and shared that two registered staff were required to count at each shift change and during a contingency count if there were any change in the registered staff at any other time.

Another home care area medication room was observed. The RPN acknowledged that there were missing signatures on the controlled substance shift counts and shared that registered staff received education not too long ago related to the completion and documentation of the narcotic shift count.

Another home care area medication room was observed. The controlled substance shift count records were missing registered staff signatures. The Registered Nurse (RN) explained that they had forgotten to sign the controlled substance shift count record and stated that they were present during the count with the outgoing night nurse. The RN shared they have received education on completing the narcotic count record during orientation, and also during a two day training session presented by pharmacy in early spring. The RN stated a controlled substance count was to be completed whenever there was a change in nurses.

Another home care area medication room was observed. The RN acknowledged that the signage on the controlled substance count sheet during the sign in of the evening shift was not completed and that the expectation was that both registered staff were to sign at the time of the narcotic count.

The Staff Educator acknowledged that the shift narcotic count required two registered staff signatures at each shift count every day.

The DOC acknowledged there were multiple missing signatures on the controlled substance shift count and that there was no documented evidence that two staff were present for the narcotic shift counts on multiple occasions.

B) To achieve compliance with O. Reg. 79/10, s. 114 (1), the licensee was to develop an interdisciplinary medication management system that provided safe medication management. As part of Compliance Order (CO) #901 issued during Critical Incident (CI) inspection #2016_254610_0033, the licensee was required to educate all registered staff regarding the policy and procedures for unused or wasted medication for storage; and implement the procedure on administering medications from properly labelled vials, packages, strip pouches, and blister packs dispensed from the home's pharmacy service provider.

The licensee was required by O. Reg. 79/10, s. 136 (1) to have a written drug destruction and disposal policy. O. Reg. 79/10, s. 136 (6) stated a drug was considered to be destroyed when it was altered or denatured to such an extent that its consumption was rendered impossible or improbable.

The licensee failed to comply with O. Reg. 79/10, s. 8 (1)(b), by failing to ensure the "Disposal of Non-Controlled Medications Policy 5.6." and the "Resident Rights, Care and Services - Medication Management - Drug Disposal and Wasting of Medications and Wasting of Medications" policy that was required by the Long-Term Care Homes Act, 2007 or O. Reg. 79/10, was complied with.

The "Disposal of Non-Controlled Medications Policy 5.6." dated June 2016 stated in preparation for waste pick up by the medical waste collection company; inhalers, liquid, nasal, eye and ear preparations were placed or opened and dumped in the buckets. The medication should be denatured, making consumption impossible or improbable, by using water or discontinued liquid medication to completely destroy the medication.

The "Resident Rights, Care and Services - Medication Management - Drug Disposal and Wasting of Medications and Wasting of Medications" policy with a revised date of July 20, 2017, stated drug destruction shall be completed by denaturing the contents of the disposed medications in the medical waste

disposal bucket.

A medication room was observed. The drug destruction waste bucket stored in the medication room had two full bottles of medication sitting in the bucket. The medication containers were not emptied into the bucket and could be removed by the Inspector. Registered Practical Nurse (RPN) explained that liquids should be emptied from their container before placement into the destruction bucket and that the medication from the two bottles should have been emptied.

C) To achieve compliance with O. Reg. 79/10, s. 114 (1), the licensee was to develop an interdisciplinary medication management system that provided safe medication management. As part of Compliance Order (CO) #901 issued during Critical Incident (CI) inspection #2016_254610_0033, the licensee was required to educate and train all staff on the licensee's policy and the legislative requirements for drug destruction of a controlled substance. This education will include training for all registered staff with respect to the licensee's drug destruction and disposal policy and how to complete the documentation record to ensure the following was documented: the date of removal of the drug from the drug storage area; the name of the resident for whom the drug was prescribed; the prescription number of the drug, the drug's name, strength and quantity, the reason for destruction; the date when the drug was destroyed; the names of the members of the team who destroyed the drug and the manner of destruction of the drug.

The licensee was required by O. Reg. 79/10, s. 136(1) to have a written drug destruction and disposal policy. O. Reg. 79/10, s. 136(4) stated that where a drug that was to be destroyed was a controlled substance, the drug destruction and disposal policy must provide that the team acting together shall document the following in the drug record:
1. The date of removal of the drug from the drug storage area.
2. The name of the resident for whom the drug was prescribed, where applicable.
3. The prescription number of the drug, where applicable.
4. The drug's name, strength and quantity.
5. The reason for destruction.
6. The date when the drug was destroyed.
7. The names of the members of the team who destroyed the drug.
8. The manner of destruction of the drug.

The licensee failed to comply with O. Reg. 79/10, s. 8(1)(b), by failing to ensure the "Disposal of Controlled Medications Policy 5.7." that was required by the Long-Term Care Homes Act, 2007 or O. Reg. 79/10, was complied with.

The Silver Fox Pharmacy Policy and Procedure Educational Session by PowerPoint was presented to all registered staff in March 2017 with respect to the licensee's drug destruction and disposal policy and how to complete the documentation record.

The "Disposal of Controlled Medications Policy 5.7." dated June 2016 stated the following information must be documented on the controlled substance administration record for the controlled medication to be destroyed:
• the prescription number,
• the date the drug was dispensed,
• the name of the resident,
• the medication name, strength directions and dosage, and
• the reason for destruction.

The narcotic and controlled substance destruction was observed with the Consultant Pharmacist and the Registered Nurse (RN) participating in the process. The following documentation errors were noted by the RN on the following five "Controlled Substance Administration Records"(CSAR):
1. The count documented that the amount remaining was indicated as one "1.0", but the quantity removed was "0.5". The RN stated the dose was taken from the as needed (PRN) medication card rather than from the dose for every six hours.
2. The CSAR was missing the second nurse signature for the removal date.
3. The CSAR was missing the removal date.
4. The CSAR was missing the reason for removal.
5. The CSAR was missing the second nurse signature for the removal date and the quantity removed did not match the quantity destroyed.

The DOC acknowledged there was missing information on the controlled substance administration records identified during the drug destruction.

D) To achieve compliance with O. Reg. 79/10, s. 114 (1), the licensee was to develop an interdisciplinary medication management system that provided safe medication management. As part of Compliance Order (CO) #901 issued during Critical Incident (CI) inspection #2016_254610_0033, the licensee was required to educate all registered staff regarding the policy and procedures for unused or

wasted medication for storage; and implement the procedure on administering medications from properly labelled vials, packages, strip pouches, and blister packs dispensed from the home's pharmacy service provider.

The licensee was required by O. Reg. 79/10, s. 136(1) to have a written drug destruction and disposal policy. O. Reg. 79/10, s. 136(2)1 stated drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

The licensee failed to comply with O. Reg. 79/10, s. 8(1)(b), by failing to ensure that the "Safe Storage of Medication Policy 5.1." and "Disposal of Non-Controlled Medications Policy 5.6." that was required by the Long-Term Care Homes Act, 2007 or O. Reg. 79/10, was complied with.

The Silver Fox Pharmacy Policy and Procedure Educational Session by PowerPoint was presented to all registered staff in March 2017 with respect to safe storage of medications. All medication should remain in their original pharmacy label container until they are administered to an individual. Unused are wasted medication should be stored separately from active medication in a locked area until destruction.

The "Safe Storage of Medication Policy 5.1." dated June 2016 stated all medication should remain in their original Silver Fox labelled container until they were administered to an individual and unused wasted medication should be stored separately from active medication in a locked area until it can be returned to Silver Fox pharmacy.

The "Disposal of Non-Controlled Medications Policy 5.6." dated June 2016 stated medications awaiting destruction must be stored in a secure designated area within the home, separate from medications that are to be administered to the residents. In preparation for waste pick up by the medical waste collection company; inhalers, liquid, nasal, eye and ear preparations are placed or opened and dumped in the buckets.

An identified medication room was observed. The top drawer of the medication cart had two loose pills outside of the original or strip packaging from pharmacy. The RPN and the RN could not identify which resident the two tablets belonged to, but the RN suspected it might be from the emergency stock.

A medication cart was observed. The fifth drawer of the medication cart contained various medications for destruction sitting in a blue container:
• One unlabelled puffer
• One labelled puffer
• One labelled medication package
• One medication patch with handwritten resident initials

The Registered Nurse (RN) explained that the unlabelled box in the fifth drawer with various medications was a box that contained medications for destruction. The RN verified that the medications have been sitting in the box for a while and were not discontinued or stopped today. The RN acknowledged that the medications ready for destruction should not be left in the medication cart and should be denatured as soon as possible.

E) To achieve compliance with O. Reg. 79/10, s. 114 (1), the licensee was to develop an interdisciplinary medication management system that provided safe medication management. As part of Compliance Order (CO) #901 issued during Critical Incident (CI) inspection #2016_254610_0033, the licensee was required to educate all registered staff regarding the policy and procedures for unused or wasted medication for storage; and implement the procedure on administering medications from properly labelled vials, packages, strip pouches, and blister packs dispensed from the home's pharmacy service provider. Also, the licensee was required to develop a procedure to ensure expired medications were removed from the medication carts and evaluate the implementation of the procedure to ensure it was followed by all registered staff.

The licensee was required by O. Reg. 79/10, s. 136(1) to have a written drug destruction and disposal policy that provides for the ongoing identification, destruction and disposal of:
(a) all expired drugs;
(b) all drugs with illegible labels;
(c) all drugs that are in containers that do not meet the requirements for marking containers specified under subsection 156 (3) of the Drug and Pharmacies Regulation Act; and
(d) a resident's drugs where,
(i) the prescriber attending the resident orders that the use of the drug be discontinued,
(ii) the resident dies, subject to obtaining the written approval of the person who

has signed the medical certificate of death under the Vital Statistics Act or the resident's attending physician, or
(iii) the resident is discharged and the drugs prescribed for the resident are not sent with the resident under section 128.

The licensee failed to comply with O. Reg. 79/10, s. 8(1)(b), by failing to ensure that medication policies that were required by the Long-Term Care Homes Act, 2007 or O.Reg. 79/10, were complied with.

The Silver Fox Pharmacy Policy and Procedure Educational Session by PowerPoint was presented to all registered staff in March 2017. The registered staff were trained on the removal of medications from active the medication supply of all expired drugs, all drugs with illegible labels, all drugs that were in containers that do not meet the requirements for marking containers and the resident's drugs where the drug was discontinued, the resident dies, or the resident was discharged.

1) The "Resident Rights, Care and Services - Medication Management - Administration of Medications Policy Version 3" policy last revised July 20, 2017 stated registered staff would administer medications only from properly labelled files, packages, strip pouches, blister packs dispensed from pharmacy, and/or properly labelled government stock pharmaceuticals.

Inspectors observed a medication cart and noted a treatment cream with an illegible label with a resident's name handwritten on the top of the bottle. The RPN acknowledged that the treatment cream's original label provided by the pharmacy was illegible.

Inspectors observed the medication cart and noted a medication container from the "Emergency Supply" with a handwritten label in blue pen with a resident's name and the medication pen inside the container had an illegible label with no name on the pen. The RPN acknowledged that the medication pen was illegible, and verified that there was no name on the pen, only a hand written name on the box. The DOC also acknowledged that the medication pen label taken from emergency drug supply was illegible and have since ordered a new medication pen.

Inspectors observed the medication cart and noted a medication pen with an illegible label. The RN acknowledged that the resident's medication pen label

was illegible, that pharmacy should have been faxed for a new label, and the medication removed from the cart.

2) The "Resident Rights, Care and Services - Medication Management - Drug Disposal and Wasting of Medications and Wasting of Medications" policy last revised date of July 20, 2017 stated registered staff will remove medications which were discontinued, unused, expired, recalled, deteriorated, unlabeled and in containers with worn, illegible, damaged, incomplete or missing labels.

The medication room was observed. The medication cart had one bottle of medication that had expired in June 2017. The RPN acknowledged that the medication had an expiration date of June 2017.

The Staff Educator stated education was provided to all registered staff related to expired medications and staff were responsible for checking expiration dates before administration and placing expired medications into the white destruction buckets in each medication room. Expired medications were evaluated as part of the home audit to ensure no expired medications were in the medication carts.

An identified medication room was observed. The medication cart had one bottle of medication that had expired in June 2017. The RPN acknowledged that the medication expired in June 2017, and that all expired medications should be disposed according to the policy.

The medication room was observed. The medication cart had two bottles of medication that had expired in June 2017. The RN acknowledged that the medications expired in June 2017.

The Staff Educator provided a copy of an email related to "Drug Expiration" and shared that the Chief Quality & Clinical Services Officer from Silver Fox Pharmacy stated, "By definition, the products expire at the end of the month unless a date is specified."

The Medication Systems Audits completed in July 2017 for all four home care areas documented that medications past their date of use have been removed from the active stock, including expired medications. The DOC acknowledged that there were discrepancies between the information documented in the audit and what was observed in the medication carts.

3) The "Safe Storage of Medication Policy 5.1." dated June 2016 stated all medications must be stored in a locked medication room or cabinet and unused medication should be stored in a locked area until it can be returned to Silver Fox Pharmacy.

The "Disposal of Non-Controlled Medications Policy 5.6." dated June 2016 stated non-controlled medications that are to be disposed of must be stored in a secure designated area within the home.

The Medication Incident Notice completed for a resident had the strip package containing multiple medications stapled to the medication incident report.

The Medication Incident Notice completed for a resident had the strip package containing medication tablets stapled to the medication incident report.

The DOC acknowledged that the missed medications for the resident and the discontinued medication for the other resident should have been disposed of according to policy.

The licensee failed to ensure the "Resident Rights, Care and Services - Medication Management - Administration of Medications Policy Version 3", the "Resident Rights, Care and Services - Medication Management - Drug Disposal and Wasting of Medications and Wasting of Medications" policy", the "Safe Storage of Medication Policy 5.1."and the "Disposal of Non-Controlled Medications Policy 5.6." was complied with.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. There is a compliance history of this legislation being issued in the home on February 7, 2017 as an immediate Compliance Order #901 during Critical Incident inspection #2016_254610_0033.

There was also a previous history of non-compliance related to the following:
• O. Reg. 79/10, s. 129 issued on April 2, 2014 as a Written Notification (WN),
• O. Reg. 79/10, s. 131 (3) issued on January 24, 2014 as a WN and Voluntary Plan of Correction (VPC), and
• O. Reg. 79/10, s. 8 (1) (b) issued on February 9, 2016, February 3, 2015, April 16, 2015, and May 24, 2014 as a WN and VPC. [s. 114. (1)]
(563)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 : Nov 30, 2017

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

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.

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, 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)
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 6th day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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Name of Inspector / Nom de l'inspecteur : Melanie Northey

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