Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 25, 2020	2020_664602_0005 (A2)	018700-19, 019786-19, 022568-19, 023788-19, 000240-20	Critical Incident System

Licensee/Titulaire de permis

Sherwood Park Manor
1814 County Road #2 East BROCKVILLE ON K6V 5T1

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

Sherwood Park Manor
1814 County Road #2 East BROCKVILLE ON K6V 5T1

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

Amended by WENDY BROWN (602) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Due to the current emergency orders in place amid the coronavirus pandemic the compliance orders will be amended to October 31, 2020.

Issued on this 25th day of June, 2020 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Amended by WENDY BROWN (602) - (A2)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 21-24, 30 & 31, February 4-7, 2020

The following inspections were completed:

Log#018700-19/CIS #264-000011-19 - regarding conduct of staff,

Log#019786-19/CIS #264-000012-19 - regarding a fall with injury and transfer to hospital,

Log#022568-19/CIS #264-000014-19 - regarding alleged staff to resident neglect, and

Log#023788-19/CIS #264-000015-19 - regarding alleged staff to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Resident and Family Services Manager, the Assistant Director of Care (ADOC), the Director of Care (DOC), and the Administrator.

During the course of the inspection, the inspector reviewed resident health care records: including plans of care, progress notes and electronic medication administration records, relevant policies and procedures, and made resident care and medication administration observations.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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

10 WN(s)
5 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to protect thirty - eight (38) residents from neglect by the licensee and the staff in the home.

Under O. Regs 79/10 s. 5 neglect is defined as the "failure to provide a resident with the treatment, care services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

A critical incident (CI) was reported by the licensee on a specified date, for neglect of multiple residents due to the failure to provide prescribed medication.

On a specified date, Registered Nurse (RN) #111 and Registered Practical Nurse (RPN) #113 found various medications for nine (9) residents had been discarded in unopened medication pouches in the medication waste disposal bucket; their review of resident electronic medication administration records (eMAR) indicated the medications had been marked as administered by RPN #105. The medications from numerous date were submitted to the Director of Care (DOC) #101, with an email noting the concern.

In an interview, DOC #101 indicated they looked through the medications submitted and determined no medications were of high risk. The medications were not matched with corresponding resident eMARs at that time. There was no assessment of the residents who had not received their medication. The physicians, residents, resident Power of Attorney (POA)s/Substitute Decision Maker (SDM)s and/or the Director were not notified immediately. An investigation was not commenced at that time.

On another specified date, RPN #106 alerted the Assistant Director of Care (ADOC) #102 that resident #003's morning medications had been found in their unopened medication pouches on the medication cart. Progress notes, authored by RPN #105, indicated resident #003 had refused their morning medications on two (2) specified dates.

An investigation was commenced four (4) days after the reported incident involving resident #003 by ADOC #102 who reviewed the medications previously submitted for various dates to DOC #101 and noted that corresponding resident eMARs indicated the medications had been given by RPN #105. ADOC #102

reviewed the failure of RPN #105 to provide multiple medications to 9 residents on various earlier dates and resident #003 on 2 specified mornings with DOC #101. Both ADOC #102 and DOC #101 noted that the sealed pouches still contained medications, thus the residents could not have been given their medications. Medication incident reports were not completed. Resident #003's physician, POA/SDM and the Director were not immediately notified.

RPN #105 worked an additional six (6) shifts following the report regarding resident #003 and various previous dates. DOC #101 confirmed in an interview that there was no communication with RPN #105 regarding their failure to provide medication to multiple residents until a specified date when a meeting was held with the RPN to review the incidents. RPN # 105 was placed on administrative leave to allow further investigation. It should be noted that RPN #105 did not provide medication to multiple residents on on the 6 additional shifts they worked following the incident(s).

On a specified date, DOC #101 and ADOC #102 went through the medication waste disposal buckets still in the home and found that an additional twenty - eight (28) residents had not been given their medication by RPN #105. The review of resident eMARs and unopened medication pouches revealed the prescribed medications included those used to treat a variety of conditions. DOC #101 indicated that resident physicians, the medical director and the pharmacy were verbally alerted that some residents did not receive all of their prescribed medications. The Director was notified via CIS report # 2640-000014-19. Medication incident reports were not completed. Calls to alert the SDMs/POAs of the affected residents were completed over a period of 3 days the following week.

The licensee failed to ensure 38 residents were provided medications necessary for health, safety and/or well being.

In addition the licensee failed to comply with:
1. Policy to promote zero tolerance - LTCA 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. (refer to WN #5)
2. Licensee must investigate, respond and act LTCA 2007 s. 23. (1) Every licensee of a long-term care home shall ensure that, every alleged, suspected or witnessed incident of neglect that the licensee knows of, or that is reported to the

licensee is immediately investigated, appropriate action is taken in response to every such incident and any requirements that are provided for in the regulations for investigating and responding are complied with. (refer to WN #6)
3. Reporting certain matters to Director LTCA 2007 s. 24. (1) A person who has reasonable grounds to suspect that abuse and/ or neglect has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director. (refer to WN #7).
4. Notification re incidents O. Reg. 79/10, s. 97 (1) (b) Every licensee of a long-term care home shall ensure that the resident' s substitute decision-maker, if any, and any other person specified by the resident are notified within 12 hours upon becoming aware of an alleged, suspected or witnessed incident of neglect of the resident. (refer to WN #8). [s. 19. (1)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

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

On a specified date, RN #111 and RPN #113 submitted numerous un-administered medications for 9 residents that had been marked as being administered by RPN #105 to DOC #101.

On a subsequent date, RPN #106 alerted ADOC #102 that resident #003'morning medications had been found in their unopened medication pouches on the medication cart. Progress notes, authored by RPN #105 indicated resident #003 had refused their morning medications on 2 separate specified dates.

ADOC #102 began an investigation 4 days later and reviewed the un-administered medications that had been previously submitted to DOC #101; they noted that the corresponding resident eMARs indicated the medications had been administered by RPN #105. ADOC #102 then reviewed the medication administration / documentation incidents with DOC #101. Both ADOC #102 and the DOC #101 noted the medication could not have been administered as they remained in their unopened medication pouches. The resident eMARS revealed that the un-administered medications included those used to treat a variety of conditions. In a meeting held on a specified date, RPN #105 confirmed they had not administered the medications as prescribed.

On a subsequent specified date, DOC #101 and ADOC #102 went through the medication waste disposal buckets still in the home and found sixty-one (61) unopened medication pouches for an additional 28 residents; the corresponding eMARs indicated the medication had been administered by RPN #105.

The licensee failed to ensure drugs were administered to 38 different residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(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. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident is: documented together with immediate actions to assess and maintain resident health, reported as outlined in legislation, reviewed /analysed and corrective action taken.

As noted in WN #1 numerous un-administered medications from various dates were submitted to management. Medication incident reports were not completed and there was no action taken to assess resident health at that time. The residents' physicians, pharmacy and/or POAs/SDMs were not alerted. The Director was not notified of the incidents.

On a specified date, DOC #101 and ADOC #102 went through the medication waste disposal buckets still in the home and found an additional 61 medication pouches for 28 residents that had not been administered by RPN #105 despite corresponding eMARs that indicated they been given their medication. DOC #101 indicated that resident physicians, the medical director and the pharmacy were verbally alerted to the incidents. The Director was notified via CIS report # 2640-000014-19. Medication incident reports were not completed.

In an interview, DOC #101 indicated resident physicians were verbally advised that some residents did not receive their prescribed medications. There was no documentation of the incidents provided to the physicians, the medical director, or the pharmacy. There was no review of the incidents at the home's subsequent Pharmacy and Therapeutics (P&T) meeting. A number of RNs/RPNS were reminded about expected medication administration and related documentation practices; DOC #101 could not confirm that all nursing staff had been included in the reminders/education. The Director was notified via CIS # 2640-000014-19. Medication incident reports were not completed. Calls to alert SDMs/POAs to the incidents /affected residents were completed over a period of 3 days the following week.

The licensee failed to ensure 38 residents were assessed following the discovery that they had not received prescribed medications, there was no documentation completed or review conducted specific to the incidents. There was no corrective action until after RPN #105 worked an additional 6 shifts. None of the legislated notification/reporting requirements were met. [s. 135. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that Medication Administration "Medication Pass 3-6 & Monitored Medications 6-7" Policies were complied with.

In accordance with O. Reg. 79/10, s. 114 (2), the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. Specifically, the licensee did not follow Medication Pass Policy 3-6 and Monitored Medications Policy 6-7.

Medication Pass Policy 3-6 outlines in procedure item 13. b. that “de-identification of labels and pouches by removal /blackout of resident information from prescription packaging before discarding - add 1 cup of water to medication cart garbage and agitate to ensure such labels are exposed and ink is removed” is to be completed during each medication pass.

On a specified date RN #111 was alerted to the presence of a number of unopened medication pouches for 9 residents in the medication waste disposal bucket with resident information clearly visible. The medications were submitted to DOC #101.

On a specified date, RPN #106 alerted ADOC #102 that resident #003’s morning medications from 2 different dates had been found in their unopened medication pouches with resident information clearly visible. The pouches were discarded in the waste disposal bucket; resident information was not removed.

On a subsequent specified date, DOC #101 and ADOC #102 went through the medication waste disposal buckets still in the home and found 61 medication pouches for 28 different residents with resident identification information clearly visible..

Interviews and observations with RN #108 & #109 and RPN #110 & #106 indicated staff were aware of Medication Pass Policy 3-6's direction that resident information be removed by adding water and/or other liquids used during the medication pass and followed the de-identification procedure. DOC #101 advised that staff had recently been reminded that they must ensure identifying resident information is removed from medication pouches following each medication pass.

Monitored Medications Policy 6-7: Combined Individual Monitored Medication Record with Shift Count procedure item 3. indicates staff are to "document the administration of the monitored medication on the resident’s MAR”.

On a specified date, a review of the licensee investigation file for CIS #2640-000011-19 revealed that concerns regarding narcotic administration documentation practice by RPN #104 had arisen during a review of the use of prn narcotics in the home. A subsequent meeting was held with RPN #104 to discuss narcotic administration that was missing/absent from the eMAR. RPN #104 had documented administration of narcotics on the Monitored Medication Count sheet, but had failed to enter the administration on the corresponding eMARs. DOC

#101 reminded RPN #104 of the “dangers this poses to residents when narcotics/medications are not documented appropriately and that it could potentially lead to medication errors and have grave affects" on residents.

In interviews with ADOC #102 and DOC #101 regarding RPN #104 medication administration practice it was confirmed that narcotic medications had been noted on the shift Monitored Medication Count form, however, the corresponding entry had not been made on resident eMAR(s).

The licensee failed to ensure that Medication Administration Policies specific to de-identification procedures for the safe destruction/disposal of drugs used in the home, and shift count/resident eMAR documentation procedures were complied with. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute and put in place any policy, the licensee is required to ensure that the policy is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee failed to ensure their Resident Care: Zero Tolerance of Abuse and Neglect Policy – revised September 2019 was complied with, specifically, the direction outlined under:

Investigation and Reporting of Abuse and Neglect p. 3 & 4 of 19 items 3., 4., and 6. as follows
3. "reports of … neglect will be immediately investigated in accordance with investigation procedures".
4. "appropriate action will be taken in response to any alleged, witnessed or unwitnessed incident of resident abuse of neglect".
6. "the report to the MOHLTC Director must meet the requirements in the LTCA… - Appendix B: A person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or risk for r harm to a resident shall immediately report the suspicion and the information upon which it is based to the director", and
Obligation p. 4 & 5 of 19: Notification of Residents SDM and Others as follows: The residents SDM, if any, and any other person the resident specifies will be notified
a) immediately upon becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that resulted in physical injury or pain to the resident, or distress to the resident that has the potential to be detrimental to the resident's health and well being and
b) within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident

As noted in WN #1, multiple incidents of neglect due to failure to provide medication were reported to the licensee; an investigation was not immediately commenced, there was no assessment of residents who had not received their medication, the physicians, residents, resident POAs/SDMs and/or the Director were not immediately notified.

On a specified date, RPN #106 alerted ADOC #102 that resident #003's morning medications had not been provided. An investigation was commenced 4 days later, by ADOC #102. RPN #105 continued to work an additional 6 shifts. DOC #101 confirmed in an interview that there was no communication regarding RPN #105's failure to provide medications to multiple residents until a subsequent specified date when a meeting was held with the RPN to review the incidents.

RPN # 105 was placed on administrative leave to allow further investigation. It should be noted that RPN #105 failed to provide medications to multiple residents during the 6 shifts they worked following report of the incidents involving resident #003.

The Director was notified via CIS report # 2640-000014-19. Calls to alert the SDMs/POAs of the affected residents were completed over a 3 day period the following week.

The licensee failed to comply with Resident Care: Zero Tolerance of Abuse and Neglect Policy direction specific to Investigation and Reporting of Abuse and Neglect:
- appropriate action, investigation and legislated reporting requirements
- immediate reporting of alleged, suspected or witnessed neglect to the Director and Obligation:
- notification of residents SDM within 12 hours of becoming aware of an alleged, suspected or witnessed incident of neglect.

2. A CI was reported by the licensee on a specified date for alleged staff to resident sexual abuse of resident #008.

Resident #008 has 3 POAs. On a specified date, resident #008 told RPN #121 that Personal Support Worker (PSW) #119 had touched them inappropriately down the front of their brief while providing care. RPN #121 immediately alerted RN #112 who reported the allegation to DOC #101 via telephone on a specified date. DOC #101 instructed RN #112 to remove/change PSW #119's assignment for the next shift to ensure the PSW was not on the unit until an investigation could be completed. RN #112 met with the resident and their POA/second contact to advise that the DOC had been alerted and that there would be an investigation.

PSW #119 was interviewed by DOC #101 and indicated they had performed resident #008's morning care with PSW #120; at no time was either PSW alone with the resident. PSW #119 further advised that resident #008 did not seem upset or to have any concerns during their care. The DOC directed PSW #119 that they were not to be alone with certain residents. DOC #101 met with resident #008 and their POA/second contact; resident #008 shared that they were uncomfortable with specific staff providing care. DOC #101 assured the resident that they would no longer be provided care by specified PSW staff.

The DOC #101 held a meeting with resident #008 and their POA/first contact a specified period of time later to provide clarity and reassurance about the plan of care. During the meeting the incident with PSW #119 was reviewed, resident #008's POA/first contact advised that they had no knowledge of the incident and indicated they were upset as they should have been informed at time the time the incident occurred. Resident #008 renewed their allegation that PSW #119 had put their hands down their brief. The police and the Director were notified.

The licensee failed to comply with their Resident Care: Zero Tolerance of Abuse and Neglect Policy direction specific to:
Investigation and Reporting of Abuse and Neglect:
- immediate reporting of alleged, suspected or witnessed incident(s) of abuse to the Director
and Obligation:
- notification of residents SDM/POA immediately upon becoming aware of an alleged, suspected or witnessed incident of abuse. [s. 20. (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 their written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The license failed to a) immediately investigate b) take appropriate action and c) respond to every alleged, suspected or witnessed incident of neglect

As outlined in WN #1 the multiple incidents of neglect due to failure to provide medications to residents reported on various dates were not immediately investigated.

DOC #101 confirmed in an interview that there was no communication with RPN #105 regarding their failure to provide medications to multiple residents until the end of their shift on a specified date when they were placed on administrative leave.

On a subsequent specified date, DOC #101 and ADOC #102 went through the medication waste disposal buckets still in the home and found that an additional 28 residents had not been provided their medication by RPN #105.

The license failed to immediately investigate, act and respond to multiple incidents of neglect. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that, (a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations; and (b) appropriate action is taken in response to every such incident; and (c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee failed to immediately report improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to a resident to the Director.

As outlined in WN #1, the multiple incidents of neglect due to failure to provide medications reported to DOC #101 on a specified date, and ADOC #102 on a subsequent specified date were not immediately reported to the Director.

On a specified date later, DOC #101 and ADOC #102 went through the medication waste disposal buckets still in the home and found that an additional 28 residents had not been provided their medication by RPN #105. The Director was notified via CIS report # 2640-000014-19.

2. The license failed to immediately inform the Director of an alleged, suspected or witnessed incident of sexual abuse of a resident.

A CI was reported by the licensee on a specified date for alleged staff to resident sexual abuse of resident #008.

On a specified date, resident #008 told a nursing staff that a PSW had touched them inappropriately while providing morning care. DOC #101 was immediately alerted via telephone. An investigation was commenced on a specified date. The Director was notified of the alleged incident of abuse a subsequent period of time after the incident was reported.

The licensee failed to immediately notify the Director upon becoming aware of multiple incidents of neglect and an alleged incident of staff to resident sexual abuse. [s. 24. (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 a person who has reasonable grounds to suspect that neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident is immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

A review of the documents provided by the licensee indicated that P&T committee meetings were held on June 20, 2018, December 18, 2018, May 28, 2019 and November 19, 2019; time between meetings was six (6), five (5) and 6 months respectively. There had not been a P&T meeting since November 19, 2019.

Minutes from the December 18, 2018 meeting and notes from the November 19, 2019 minutes indicate the Administrator #100 was not in attendance at either meeting. There were no minutes provided for the June 20, 2018 or the May 28, 2019 meeting(s) thus attendees could not be confirmed.

The licensee failed to ensure meetings were held quarterly, with attendance by the complete interdisciplinary team. [s. 115. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. Resident #008 has 3 POAs including a first contact, second contact and third contact. On a specified date, resident #008 told RPN #121 that PSW #119 had touched them inappropriately while providing care. DOC #101 was immediately alerted via telephone. RN #112 met with the resident and their POA/second contact to advise that the DOC had been alerted and that there would be an investigation. Resident #008's POA/first contact was not notified.

On a specified date, DOC #101 met with resident #008 and their POA/second contact; resident #008 shared that they were uncomfortable with specific staff providing care. DOC #101 assured the resident that they would no longer be provided care by specified staff.

Another meeting was held on a subsequent date with resident #008 and their POA/first contact in an effort to provide clarity and reassurance about the plan of care. During the meeting the incident was reviewed; resident #008’s POA/first contact advised that they had no knowledge of the earlier incident and indicated they were upset as they should have been informed at time the incident occurred.

The licensee failed to notify resident #008s POA/first contact immediately upon

becoming aware of an alleged, suspected or witnessed incident of abuse. [s. 97. (1) (a)]

2. The licensee failed to notify resident POAs/SDMs within 12 hours upon becoming aware of incidents of neglect.

On a specified date, RN #111 alerted DOC #101 that medications for 9 residents had been discarded in the medication waste disposal bucket; their review of resident eMARs indicated the medications had been marked as administered by RPN #105. The POAs/SDMs were not notified of the incidents within 12 hours of becoming aware of the neglect.

On a subsequent specified date, RPN #106 alerted ADOC #102 that resident #003's morning medications had not been provided. The POA/SDM was not alerted to the RPN's failure to provide medication to resident #003 on these dates within 12 hours of becoming aware of the neglect.

On a specified date, DOC #101 and ADOC #102 found an additional 28 residents had not been provided their medication by RPN #105. Calls to alert the SDMs/POAs of the affected residents were completed over a period of 3 days the following week.

The licensee failed to notify the 38 POAs/SDMs within 12 hours of becoming aware of resident neglect. [s. 97. (1) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the report to the Director included:
1. A description of the incident, including the date and time of the incident and the events leading up to the incident
2. A description of the individuals involved in the incident, including resident staff members who were present at or discovered the incident.

As outlined in WN #1 a CIS report was submitted by the licensee regarding the neglect of 38 residents due to failure to provide multiple prescribed medications.

A review of the CIS report found the following information was not included:
- The date and time of the first incident(s).
- The date and time of the subsequent two incidents.
- The names of the 9 residents who were not provided their prescribed medication in the first incident(s).
- The name of resident #003 who was not provided their prescribed medication on the second incident(s).
- The names of the 28 residents who were not provided their prescribed medication in a third discovered incident(s).
- The names of the staff members who discovered the first incident(s).
- The name of the staff who discovered the second incident(s).
- The name of the staff who failed to provide 38 residents their prescribed medication.

The licensee failed to include the date(s) and time(s) of the incident(s), the names of all residents, and staff members who discovered/were involved in the incident (s) in the CIS report to the Director. [s. 104. (1) 1.]

Issued on this 25th day of June, 2020 (A2)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by WENDY BROWN (602) - (A2)
Inspection No. / No de l'inspection :	2020_664602_0005 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	018700-19, 019786-19, 022568-19, 023788-19, 000240-20 (A2)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 25, 2020(A2)
Licensee / Titulaire de permis :	Sherwood Park Manor 1814 County Road #2 East, BROCKVILLE, ON, K6V-5T1
LTC Home / Foyer de SLD :	Sherwood Park Manor 1814 County Road #2 East, BROCKVILLE, ON, K6V-5T1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Alfred O'Rourke

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Sherwood Park Manor, you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with LTCHA, 2007, S.O. 2007, c. 8, s. 19 (1).

Specifically, the licensee shall:
1) ensure all allegations of resident neglect and abuse are reported and investigated in accordance with the legislated requirements.
2) develop and implement a written process to audit each investigation into allegations of resident neglect and abuse to ensure ongoing compliance with all aspects of reporting, investigation process and related response(s) in accordance with the legislation. Additionally, the home will develop and implement a written plan of corrective action to address any failures identified.
3) provide education for management and direct care staff specific to Policy: Zero Tolerance of Abuse and Neglect, Resident Care Section - revised September 2019, in addition to annual education, that highlights:
a. definition of neglect and abuse
b. requirements specific to responding (2007, c. 8, s. 23 (1).), reporting (2007, c. 8, s. 20 (1)., 2007, c. 8, s. 24 (1). and O. Reg. 79/10, s. 97 (1).) and investigating & acting on (2007, c. 8, s. 23 (1).) every alleged, suspected or witnessed incident of resident neglect or abuse by staff.
4) keep a documented record detailing the education sessions held with all management and direct care staff that includes: session dates, topics reviewed, list of all attendees with corresponding attendance dates, and name of instructor(s).

Grounds / Motifs :

1. The licensee failed to protect thirty - eight (38) residents from neglect by the licensee and the staff in the home.

Under O. Regs 79/10 s. 5 neglect is defined as the "failure to provide a resident with the treatment, care services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents".

A critical incident (CI) was reported by the licensee on a specified date, for neglect of multiple residents due to the failure to provide prescribed medication.

On a specified date, Registered Nurse (RN) #111 and Registered Practical Nurse (RPN) #113 found various medications for nine (9) residents had been discarded in unopened medication pouches in the medication waste disposal bucket; their review of resident electronic medication administration records (eMAR) indicated the medications had been marked as administered by RPN #105. The medications from numerous date were submitted to the Director of Care (DOC) #101, with an email noting the concern.

In an interview, DOC #101 indicated they looked through the medications submitted and determined no medications were of high risk. The medications were not matched with corresponding resident eMARs at that time. There was no assessment of the residents who had not received their medication. The physicians, residents, resident Power of Attorney (POA)s/Substitute Decision Maker (SDM)s and/or the Director were not notified immediately. An investigation was not commenced at that time.

On another specified date, RPN #106 alerted the Assistant Director of Care (ADOC) #102 that resident #003's morning medications had been found in their unopened medication pouches on the medication cart. Progress notes, authored by RPN #105, indicated resident #003 had refused their morning medications on two (2) specified dates.

An investigation was commenced four (4) days after the reported incident involving resident #003 by ADOC #102 who reviewed the medications previously submitted for various dates to DOC #101 and noted that corresponding resident eMARs indicated the medications had been given by RPN #105. ADOC #102 reviewed the failure of

RPN #105 to provide multiple medications to 9 residents on various earlier dates and resident #003 on 2 specified mornings with DOC #101. Both ADOC #102 and DOC #101 noted that the sealed pouches still contained medications, thus the residents could not have been given their medications. Medication incident reports were not completed. Resident #003's physician, POA/SDM and the Director were not immediately notified.

RPN #105 worked an additional six (6) shifts following the report regarding resident #003 and various previous dates. DOC #101 confirmed in an interview that there was no communication with RPN #105 regarding their failure to provide medication to multiple residents until a specified date when a meeting was held with the RPN to review the incidents. RPN # 105 was placed on administrative leave to allow further investigation. It should be noted that RPN #105 did not provide medication to multiple residents on on the 6 additional shifts they worked following the incident(s).

On a specified date, DOC #101 and ADOC #102 went through the medication waste disposal buckets still in the home and found that an additional twenty - eight (28) residents had not been given their medication by RPN #105. The review of resident eMARs and unopened medication pouches revealed the prescribed medications included those used to treat a variety of conditions. DOC #101 indicated that resident physicians, the medical director and the pharmacy were verbally alerted that some residents did not receive all of their prescribed medications. The Director was notified via CIS report # 2640-000014-19. Medication incident reports were not completed. Calls to alert the SDMs/POAs of the affected residents were completed over a period of 3 days the following week.

The licensee failed to ensure 38 residents were provided medications necessary for health, safety and/or well being.

In addition the licensee failed to comply with:
1. Policy to promote zero tolerance - LTCA 2007 s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. (refer to WN #5)
2. Licensee must investigate, respond and act LTCA 2007 s. 23. (1) Every licensee of a long-term care home shall ensure that, every alleged, suspected or witnessed

incident of neglect that the licensee knows of, or that is reported to the licensee is immediately investigated, appropriate action is taken in response to every such incident and any requirements that are provided for in the regulations for investigating and responding are complied with. (refer to WN #6)
3. Reporting certain matters to Director LTCA 2007 s. 24. (1) A person who has reasonable grounds to suspect that abuse and/ or neglect has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director. (refer to WN #7).
4. Notification re incidents O. Reg. 79/10, s. 97 (1) (b) Every licensee of a long-term care home shall ensure that the resident' s substitute decision-maker, if any, and any other person specified by the resident are notified within 12 hours upon becoming aware of an alleged, suspected or witnessed incident of neglect of the resident. (refer to WN #8). [s. 19. (1)]

The decision to issue this non-compliance as an order was based on the following: The severity of this issue was determined to be a level 3 as there was actual risk of harm to multiple residents. The scope of the issue was a level 2 as a pattern: 38 of 107 (36%) residents were affected. The home had a level three history as they have had multiple non-compliances in similar areas:
- Compliance Order (CO) issued June 2019 - 2019_702197_0013 s. 20 policy to promote zero tolerance - Prevention of Abuse Neglect and retaliation
- Voluntary plan of correction (VPC) issued June 2019 - 2019_702197_0013 s. 23 licensee must investigate respond and act - Prevention of Abuse Neglect and retaliation
- Voluntary plan of correction (VPC) issued June 2019 - 2019_702197_0013 s. 24 reporting to director - Prevention of Abuse Neglect and retaliation
- Voluntary plan of correction (VPC) issued June 2019 - 2019_702197_0015 r. 97 Notification re incidents - Prevention of Abuse Neglect and retaliation
(602)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2020(A2)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 131 (2).

Specifically, the licensee shall:
a) ensure all residents receive their medication in accordance with the directions for use specified by the prescriber,
b) ensure all registered nursing staff administering medication receive education related to Medication Administration: Medication Pass - Section 3-6 de-identification procedures and Monitored Medications - Section 6-7 narcotics count eMAR documentation process.
c) maintain a documented record detailing the education sessions held with all registered nursing staff that includes: session dates, topics reviewed, list of all registered nursing staff with corresponding attendance dates, and name of instructor(s).

Grounds / Motifs :

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

On a specified date, RN #111 and RPN #113 submitted numerous un-administered medications for 9 residents that had been marked as being administered by RPN #105 to DOC #101.

On a subsequent date, RPN #106 alerted ADOC #102 that resident #003'morning medications had been found in their unopened medication pouches on the medication cart. Progress notes, authored by RPN #105 indicated resident #003 had

refused their morning medications on 2 separate specified dates.

ADOC #102 began an investigation 4 days later and reviewed the un-administered medications that had been previously submitted to DOC #101; they noted that the corresponding resident eMARs indicated the medications had been administered by RPN #105. ADOC #102 then reviewed the medication administration / documentation incidents with DOC #101. Both ADOC #102 and the DOC #101 noted the medication could not have been administered as they remained in their unopened medication pouches. The resident eMARS revealed that the un-administered medications included those used to treat a variety of conditions. In a meeting held on a specified date, RPN #105 confirmed they had not administered the medications as prescribed.

On a subsequent specified date, DOC #101 and ADOC #102 went through the medication waste disposal buckets still in the home and found sixty-one (61) unopened medication pouches for an additional 28 residents; the corresponding eMARs indicated the medication had been administered by RPN #105.

The licensee failed to ensure drugs were administered to 38 different residents in accordance with the directions for use specified by the prescriber.

The decision to issue this non-compliance as a compliance order was based on the following:
The severity of the issue was a level 3 as there was actual risk to multiple residents. The scope of the issue was determined to be a level two due to the pattern established. In addition, the home had a level three compliance history of one or more related non compliance(s) in the last 36 months
-Written Notification (WN) and Voluntary Plan of Correction (VPC) issued January 2019 (2018_765541_0017).
-Written Notification (WN) and Voluntary Plan of Correction (VPC) issued October 2017 (2018_664602_0028). (602)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2020(A2)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(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. O. Reg. 79/10, s. 135 (1).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 135 (1).

Specifically, the licensee shall:
a) ensure every medication incident involving residents are documented together with a record of the immediate actions taken to assess and maintain the resident's health, and
b) ensure every medication incident involving residents are reported to the resident, resident's substitute decision-maker, if any, the prescriber of the drug, and the resident's attending physician or the registered nurse in the extended class attending the resident.
c) develop a written process to audit each medication incident to ensure ongoing compliance with documentation, action(s) taken and reporting in accordance with the legislation. Additionally, the home will develop a written plan of corrective action to address any failures identified.

Grounds / Motifs :

1. The licensee failed to ensure that every medication incident is: documented

together with immediate actions to assess and maintain resident health, reported as outlined in legislation, reviewed /analysed and corrective action taken.

As noted in WN #1 numerous un-administered medications from various dates were submitted to management. Medication incident reports were not completed and there was no action taken to assess resident health at that time. The residents' physicians, pharmacy and/or POAs/SDMs were not alerted. The Director was not notified of the incidents.

On a specified date, DOC #101 and ADOC #102 went through the medication waste disposal buckets still in the home and found an additional 61 medication pouches for 28 residents that had not been administered by RPN #105 despite corresponding eMARs that indicated they been given their medication. DOC #101 indicated that resident physicians, the medical director and the pharmacy were verbally alerted to the incidents. The Director was notified via CIS report # 2640-000014-19. Medication incident reports were not completed.

In an interview, DOC #101 indicated resident physicians were verbally advised that some residents did not receive their prescribed medications. There was no documentation of the incidents provided to the physicians, the medical director, or the pharmacy. There was no review of the incidents at the home's subsequent Pharmacy and Therapeutics (P&T) meeting. A number of RNs/RPNS were reminded about expected medication administration and related documentation practices; DOC #101 could not confirm that all nursing staff had been included in the reminders/education. The Director was notified via CIS # 2640-000014-19. Medication incident reports were not completed. Calls to alert SDMs/POAs to the incidents /affected residents were completed over a period of 3 days the following week.

The licensee failed to ensure 38 residents were assessed following the discovery that they had not received prescribed medications, there was no documentation completed or review conducted specific to the incidents. There was no corrective action until after RPN #105 worked an additional 6 shifts. None of the legislated notification/reporting requirements were met.

The decision to issue this non-compliance as a compliance order was based on the following:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

The severity of the issue was a level 3 as there was actual risk to multiple residents. The scope of the issue was determined to be a level 2 due to the pattern established. In addition, the home had a level 3 compliance history of one or more related non compliance(s) in the last 36 months.
Regulations that included:
-Written Notification (WN) and Voluntary Plan of Correction (VPC) issued January 2019 (2018_765541_0017).
-Written Notification (WN) and Voluntary Plan of Correction (VPC) issued October 2017 (2018_664602_0028).

(602)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2020(A2)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

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

Order(s) of the Inspector

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 25th day of June, 2020 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by WENDY BROWN (602) - (A2)

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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