Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspection Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: April 19, 2023
Original Report Issue Date: March 22, 2023
Inspection Number: 2023-1172-0002 (A1)
Inspection Type: Follow up Critical Incident System
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partn
Long Term Care Home and City: Streamway Villa, Cobourg

Amended By	**Inspector who Amended Digital Signature**
Chantal Lafreniere (194)	Chantal D Lafreniere Digitally signed by Chantal D Lafreniere Date: 2023.04.19 14:13:13 -04'00'

AMENDED INSPECTION SUMMARY

This licensee inspection report has been revised to reflect an amendment under FLTCA, 2021, s. 28 (1) 2 due to a system error resulting in an incorrect compliance due date. The amendment was required for compliance order #001 to reflect a correction to the complied date from May 11, 2023, to June 8, 2023. The inspection #2023-1172-0002 was completed on March 8, 2023.

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Lead Inspector Chantal Lafreniere (194)	**Additional Inspector(s)** Kelly Burns (000722)
Amended By Chantal Lafreniere (194)	**Inspector who Amended Digital Signature** Chantal D Lafreniere Digitally signed by Chantal D Lafreniere Date: 2023.04.19 14:13:37 -04'00'

AMENDED INSPECTION SUMMARY

This licensee inspection report has been revised to reflect an amendment under FLTCA, 2021, s. 28 (1) 2 due to a system error resulting in an incorrect compliance due date. The amendment was required for compliance order #001 to reflect a correction to the complied date from May 11, 2023, to June 8, 2023. The inspection #2023-1172-0002 was completed on March 8, 2023.

INSPECTION SUMMARY

The inspection occurred on the following date, February 27 and 28, March 1, 2, 3, 6, 7, 8, 2023

The following intake(s) were inspected:

- Follow-up related to O. Reg. 246/22 - s. 102 (8)
- Critical Incident Report (CIR)related to Environmental Hazard - Loss of Power due to severe weather.

- CIR related to abuse.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022-1172-0001 related to O.Reg. 246/22, s. 102 (8) inspected by Chantal Lafreniere (194)

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

Medication Management
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)

The licensee failed to ensure the written policy to promote zero tolerance of abuse and neglect of residents was complied with, specific to the alleged abuse of a resident.

Pursuant to, O. Reg. 246/22, s. 2 (1) For the purposes of the Act, “physical abuse” means, the use of physical force by anyone other than a resident that causes physical injury or pain.

Rationale and Summary:

The licensee's policy, 'Zero Tolerance of Abuse and Neglect of Residents' directs that:
In the event of an allegation of abuse of a resident, the Charge Nurse in consultation with Manager On Call, assess risk and severity and determines the need to relieve the accused person of their duties pending investigation.

Critical Incident Report (CIR) related to alleged physical abuse of a resident, was submitted to the Director. A Personal Support Worker (PSW) was witnessed abusing a resident while providing care.

The PSW reported the allegation of abuse involving the resident to two Registered Nurses (RN's)
An Registered Practical Nurse (RPN) reported the allegations of abuse to the manager on call (MOC).

The MOC indicated they misunderstood the communication, from the RPN regarding the alleged abuse; and took no action.

The PSW schedules identified that the identified PSW worked shifts following the abuse of the resident.

The PSW confirmed working several shifts following the incident.

A Clinical Care Coordinator (CCC) confirmed that the PSW was scheduled and worked shifts, following the abuse incident.

Failing to ensure the homes policy, related to relieving an accused person of their duties pending abuse investigation, placed the residents at risk for harm.

Sources: Reviewed policy, Zero Tolerance of Abuse and Neglect of Residents, CIR, nursing schedules and staff interviews. [000722]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (a) (i)

The licensee failed to ensure that an alleged staff to resident abuse incident, involving a resident , was immediately investigated.

Rationale and Summary:

Critical Incident Report (CIR) related to alleged physical abuse of a resident, was submitted to the Director. A Personal Support Worker (PSW) was witnessed abusing a resident while providing care.

The licensee's investigation related to the abuse, indicated the PSW who witnessed the incident, had reported the abuse allegation to two Registered Nurses (RN's). An RPN reported the allegations of abuse to the manager on call (MOC). The MOC indicated they misunderstood the communication, from the RPN regarding the alleged abuse; and took no action.

The MOC and Administrator indicated the abuse of a resident should have been immediately investigated.

Failure to immediately investigate incidents of alleged, suspected or witnessed abuse placed residents at increased risk for harm.

Sources: Record review of CIR, licensee investigation notes, policies 'Zero Tolerance of Abuse and Neglect of Residents' and 'Reporting Incidents of Abuse' and staff. [000722]

WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 27 (1) (b)

The licensee failed to ensure, that appropriate action was taken in response to an incident of staff to resident physical abuse, involving a resident.

Rationale and Summary:

Critical Incident Report (CIR) related to alleged physical abuse of a resident, was submitted to the Director. A Personal Support Worker (PSW) was witnessed abusing a resident while providing care.

The licensee's investigation related to the abuse, indicated that PSW who witnessed the incident, had reported the abuse allegation to two Registered Nurses (RN's). An RPN reported the allegations of abuse to the manager on call (MOC). The MOC indicated they misunderstood the communication, from the RPN regarding the alleged abuse; and took no action.

Documentation relating to the incident, assessment of the resident and notification of the MOC, SDM,

police or the Director were not found in the resident's clinical health record.

The licensee's policies, Zero Tolerance of Abuse and Neglect of Residents, Reporting of Incidents of Abuse, and Critical Incident Notification and Investigation, all direct that every allegation of abuse, alleged, suspect, or witnessed incidents, shall be investigated.

The Critical Incident Notification and Investigation policy directs that:
-The Charge Nurse shall initiate the investigation and documentation of the critical incident and any pertinent information regarding the resident shall be documented in the resident's chart.

The Zero Tolerance of Abuse and Neglect of Residents, policy directs that:
- In cases where a staff witnesses, suspects or hears of abuse of a resident, the first course of action shall be to ensure the resident is safe; then assess needs for assessment, psychosocial or physical interventions; and provide supportive measures.

The accused PSW confirmed they worked shifts following the alleged abuse incident.

Both CCC's confirmed the PSW had worked shifts following the incident; and indicated the PSW should have been placed off work pending investigation. A CCC confirmed the RN who was initially told of the abuse incident had not documented the allegation or action taken. Both, CCC's indicated that appropriate action was not taken by registered nursing staff and the MOC involving an incident of alleged abuse of a resident.

Failure of registered nursing staff and the MOC to take appropriate action related to alleged abuse of a resident placed residents at risk of harm.

Sources: Record review of the CIR, licensee investigation notes, policies, Zero Tolerance of Abuse and Neglect of Residents, Reporting Incidents of Abuse and Critical Incident Investigation and Disclosure, and staff interviews. [000722]

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee has failed to ensure that a resident, who is known to exhibit responsive behaviours had strategies developed and implemented.

Rationale and Summary:

Critical Incident Report (CIR) related to alleged physical abuse of a resident, was submitted to the Director. A Personal Support Worker (PSW) was witnessed abusing a resident while providing care.

The resident's plan of care identified, the resident was known to exhibit responsive behaviours. Interventions had been identified and strategies developed for the care of the resident.

The plan of care, in place at the time of the incident identified two staff for care, if resident exhibited responsive behaviours, staff were to leave and reapproach; and that incidents of exhibited behaviours were to be reported promptly to registered nursing staff.

PSWs present at the time of the alleged incident indicated being aware that resident was known to exhibit responsive behaviours; both PSW's indicated being aware of interventions in place for the care of the resident, prior to the incident.

The PSW who witnessed the indicated, they and another PSW went to provide care to the resident, and indicated the resident was awake and quiet prior to care. The PSW indicated they began care, and it was, at this time the resident exhibited responsive behaviours. Both PSW's indicated they continued with resident's care despite the exhibited responsive behaviour of the resident. Both PSW's indicated they did not implement strategies, which had been developed, when resident was exhibiting responsive behaviours.

Both CCC's indicated that if a resident exhibited responsive behaviours during care, staff are to stop the care, leave and reapproach; if the behaviour continues, staff are to seek direction from registered nursing staff immediately.

Failure to ensure strategies are implemented in the care of a resident exhibiting responsive behaviours placed the resident and care staff at risk for injury and harm.

Sources: Review of the clinical record of the resident, CIR, licensee's investigation notes, and staff interviews. [000722]

WRITTEN NOTIFICATION: ACCOMMODATION SERVICES

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)

The licensee has failed to ensure that as part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices for contact surfaces.

Rationale and Summary:

During the initial tour of the home a Housekeeper confirmed using Ecolab Peroxide Multi Surface Disinfectant and Cleaner for general cleaning. The housekeeper was unaware of the products contact time, acceptable concentration levels or frequency of testing. There were no visible log sheets posted in the housekeeping closet for tracking of chemical testing.

Review of the homes policy 'Cleaning and Disinfecting High Touch Surfaces', directed that, staff were to apply the product appropriately, ensure required contact times and proper dilution of the chemical. Provincial Infectious Diseases Advisory Committee (PIDAC) Best Practices for Environmental Cleaning for Infection Prevention and Control directs, when using a disinfectant: It is important that the disinfectant be used according to the manufacturer's instructions for dilution and contact time. Where dispensing systems are used, health care facilities should verify regularly that the systems are functioning properly (e.g., use of manufacturers' test strips, calibration of dispensers).

The Environmental Service Manager (ESM) confirmed the home was utilizing Peroxide Multi Surface disinfectant cleaner for the high touch areas. ESM was unsure what the testing levels or contact time for the product. The ESM verified the solution should be tested daily, confirming that they and the full-time staff would occasionally complete the testing. The results of the testing levels for the Peroxide Multi Surface disinfectant cleaner were not documented. Some of the test strips observed had expired.

The ECOLAB representative confirmed they were responsible for calibrating the concentration of disinfectant cleaner being dispensed in the housekeeping closet. The representative stated the testing levels with strips provided were to be at 3500 parts per million (ppm). The ECOLAB representative confirmed that the Peroxide disinfectant cleaner, if decanted into a closed container (such as a squirt bottle) should be changed and/or retested in 7 days of being decanted. The Peroxide disinfectant that was decanted into open containers, such as the tubs/buckets being used by the housekeepers for the cloths to clean the high touch surfaces, should be changed after 4 hours. The ECOLAB representative stated that the home's practice for testing the Peroxide Multi Surface disinfectant cleaner, should be weekly.

Housekeepers (HSK) confirmed the home was using Peroxide Multi Surface disinfectant cleaner for high touch surfaces. HSK's confirmed that they did not test the concentration of the Peroxide Multi Surface Disinfectant cleaner. A HSK indicated the manager was the one who tested, but they would test if the colour of the solution was off. The HSK was not able to indicate what the range on the test strips was acceptable when tested. HSK completed a test for the Peroxide disinfectant dispensed in the housekeeping closet as well as a decanted bottle of the solution in the adjacent tub room with results of 2350 parts per million (ppm).

Failing to ensure that procedures were developed and implemented for cleaning and disinfecting for the low-level disinfectant 'Peroxide Multi Surface Disinfectant' cleaner, related to the testing and documentation of the concentration levels, placed the home at an increased risk for infection.

Sources: Observation of the high touch surface cleaning at the home, review of the homes 'Cleaning and Disinfecting High Touch Surfaces', policy and interview with staff and contracted [194]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee failed to ensure that the IPAC standard 9.1 to ensure that at minimum, Additional Precautions shall include: f) Additional PPE requirements including appropriate selection application, removal, and disposal, was complied with.

Rationale and Summary:

A Resident was observed to be under contact precautions. A Laundry Aide confirmed the resident was under contact precautions. A PSW was observed assisting a resident with toileting care. The PSW was observed to have a mask and gloves on during the provision of care.

The PSW confirmed being aware the resident was under contact precautions, and they should have been wearing a gown while providing personal care.

Failing to ensure that proper PPE was worn during care of a resident under contact precautions, increased the risk for the spread of the infection in the home.

Sources: Observation of staff to resident care, PPE signage and interview with staff. [194]

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL PROGRAM

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (a)

The licensee failed to ensure that a resident was monitored every shift for symptoms indicating the presence of an infection, during antibiotic therapy..

Rationale and Summary:

A memo from the IPAC lead to registered staff was provided indicating that, all residents with active infections would require a progress note on each shift, for the duration of their infection. This note should include information such as what signs and symptoms indicated infection, which antibiotic they are on and for how long, how they are responding to antibiotics, if they are improving, any new symptoms, any symptoms they are no longer displaying which they previously were, if they spoke with the doctor regarding the infection, if the infection was resolved.

Review of the symptoms management tracking sheet for a specific period indicated a resident was prescribed a specific treatment.

The electronic Medication Administration Records (eMAR) confirmed the resident was prescribed the specific treatment. The progress notes for the resident indicated that every shift documentation related to the treatment, was incomplete

An RN confirmed that residents on the tracking sheet for signs of infection, were to be documented on, in the progress notes every shift until the infection was resolved.

Another RN stated that infections are to be monitored on all shifts for the course of the infection and treatment, stating assessment could include temperature, pain, effect of antibiotic; usually charted in the progress notes. Charting should be done daily on all shifts, day, evenings, and nights while a resident is on an antibiotic treatment. The RN indicated they did not believe the resident had an infection.

Failing to ensure that residents are monitored every shift for symptoms indicating the presence of an

infection, increased the risk of infections being undetected.

Sources: IPAC memo, resident ‘s clinical health records and interview with staff. [194]

WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)

The licensee failed to ensure that the residents substitute decision-maker, were notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse of a resident.

Rationale and Summary:

Critical Incident Report (CIR) related to alleged physical abuse of a resident, was submitted to the Director. A Personal Support Worker (PSW) was witnessed abusing a resident while providing care.

The licensee’s investigation of the alleged abuse incident indicated that, a PSW witnessed the incident; and reported the abuse incident to two RN’s. The licensee’s investigation notes identified that an RPN was also aware of the alleged abuse of the resident. The investigation notes identified that resident’s SDM was not notified of the incident until four days following the alleged abuse.

Both CCC’s confirmed that resident’s SDM was not immediately notified of the alleged abuse; indicating SDM was not notified for four days.

Failure to ensure that a resident’s SDM was notified of an alleged abuse delayed the resident from being provided support by their SDM; and delayed SDM’s awareness and potential involvement in the investigation.

Sources: Review of licensee policy, Reporting Incidents of Abuse, licensee’s investigation notes, CIR, staff education records, and staff interviews. [000722]

WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105

The licensee failed to ensure the appropriate police service was immediately notified of an allegation of staff to resident abuse, involving a resident.

Rationale and Summary:

Critical Incident Report (CIR) related to alleged physical abuse of a resident, was submitted to the Director. A Personal Support Worker (PSW) was witnessed abusing a resident while providing care.

The licensee's investigation of the alleged abuse incident indicated that, a PSW witnessed the incident; and reported the abuse incident to two RN's. The licensee's investigation notes identified that an RPN and the MOC were also aware of the alleged abuse of the resident. The investigation notes identified that police were not notified of the alleged abuse for four days following the incident.

Both CCC's confirmed that two RN's an RPN and the MOC were aware of the alleged abuse of a resident. A CCC confirmed that police were not notified of the alleged abuse incident for four days.

Failing to ensure immediate police notification of any alleged, suspected or witnessed abuse of a resident placed residents at risk for harm.

Sources: Review of licensee policies, Reporting Incidents of Abuse and Critical Incident Reporting and Disclosure, the licensee investigation notes, CIR, staff training records and staff interviews. [000722]

WRITTEN NOTIFICATION: OBTAINING AND KEEPING DRUGS

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee failed to ensure that medications were stored in an area that was locked and secured.

Rationale and Summary:

Inspectors observed a medication left unattended on top of a medication cart in a resident accessible hallway; residents were observed wandering in the area.

An RN indicated that the medication should have been locked inside the medication cart.

The RPN confirmed the medication should have been stored in the locked compartment of the

medication cart when they left the area and when they were not monitoring the medication cart.

Review of the 'Medication Storage' policy directed, that medications are to be locked at all times when not attended by nurse.

Failing to ensure that medications were stored in an area that was locked and secured, increased the risk of injury to the resident.

Sources: Observation of the common areas in the home; review of the homes 'Medication Storage' policy, and interview with staff. [194]

(A1)
The following non-compliance(s) has been amended: NC #011

COMPLIANCE ORDER CO #001 PREVENTION OF ABUSE AND NEGLECT

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee must:

1. Provide education to an identified Manager on Call, specifically related to the management of abuse incidents. Keep a documented record of the education provided and who provided the education. Make available to the inspector upon request.

2. Develop and implement a formal documentation system, for tracking of Manager on Call activities specifically related to abuse of residents at the home, including what time the call was received, what direction was provided and to whom and what external parties were informed and when.

3. Complete audits of all alleged abuse incidents for a two-month period. Keep a documented record of the audits completed, including any corrective action taken. Make available to the inspector upon request.

4. Complete re-education related to management of abuse incidents with identified RN's. Keep a documented record of education provided and who provided the education. Make available to the inspector upon request.

Grounds
The licensee failed to immediately report to the Director, an allegation of staff to resident physical abuse, and the information upon which it was based.

Pursuant to O. Reg. 246/22, 2 (1), for the purposes of Act, "physical abuse" means, the use of physical force by anyone other than a resident that causes physical injury or pain.

Rationale and Summary:

Critical Incident Report (CIR) related to alleged physical abuse of a resident, was submitted to the Director. A Personal Support Worker (PSW) was witnessed abusing a resident while providing care.

The licensee's investigation concluded that the allegations of abuse were founded. The investigation notes confirmed that a PSW witnessed the alleged abuse incident and failed to immediately report the incident. The licensee's investigation provided details that two RNs, and RPN and the MOC were aware of the alleged abuse days following the incident.

The PSW, who witnessed the incident, confirmed they did not immediately report the alleged abuse.
PSW indicated they reported the incident to two RN's days following the abuse incident.
An RPN confirmed that two RN's and the MOC were aware of the alleged abuse, as reported by a PSW.
A CCC indicated the alleged abuse of a resident was not immediately reported to the Director, despite 2 RN's, a RPN and the MOC being aware of the abuse allegation.
Failure of staff to immediately report alleged, suspected or witnessed abuse placed residents at risk of harm.

Sources: A review of the license's investigation notes, a CIR, licensee policies, Zero Tolerance of Abuse and Neglect of the Resident, Reporting Incident of Abuse and Critical Incident Reporting and Disclosure and staff interviews. [000722]

This order must be complied with by June 8, 2023

COMPLIANCE ORDER CO #002 ACCOMMODATION SERVICES

NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 97

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee must:

1. Provide education to PSW #116, #115 and RN #108 related to hazardous substances in the home. Keep a documented record of the education provided and make this available to the inspector upon request.

2. Complete daily audits, for a period of two weeks of the resident areas, including hallways and common areas to ensure that all hazardous substances are kept inaccessible to residents. Keep a documented record of audits completed, noting any corrective action taken. Make this record available to the inspector upon request.

Grounds
The licensee failed to ensure that all hazardous substances at the home are kept inaccessible to residents at all times.

Rationale and Summary:

The Peroxide Multi Surface disinfectant cleaner, squirt bottle was observed on a cart outside of the tub room, and on the outer ledge of the nursing station, accessible to residents. The ESM confirmed that the home utilized Peroxide Multi Surface Disinfectant cleaner for high touch areas, with a DIN #02412314.

A PSW confirmed they had removed the cart from the tub room and placed it in the hall when completing baths. The PSW stated they were unaware the Peroxide Multi surface disinfectant cleaner was on the cart.

The RN confirmed that the cart found in the hallway, would have been the responsibility of the PSW. The RN stated they did not know why the chemical was left outside the nursing station.

The homes 'Chemical Storage' policy directed that all chemical shall be stored in a location with a locking mechanism.

Failing to ensure that hazardous substances at the home are kept inaccessible to residents at all times, placed the residents at risk for injury.

Sources: Observations, chemical storage policy, Peroxide Multi Surface Disinfectant cleaner information sheet and interview with staff. [194]

This order must be complied with by June 8, 2023

COMPLIANCE ORDER CO #003 OBTAINING AND KEEPING DRUGS

NC #013 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 139 1.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee must:

1. Provide education to the Registered staff #108, related to distribution and secure storage of medicated treatment creams at the home. Keep a documented record of education provided and who attend. Make the records available to the inspector upon request.

2. Conduct daily audits, for a two-week period, related to the safe storage of medicated treatment creams at the home. Keep a record of the audits completed for the two-week period, along with any corrective action taken. Make this audits available to the inspector upon request.

Grounds
The licensee failed to ensure that steps were taken to ensure the security of the drug supply, including the following, all areas where drugs are stored shall be kept locked at all times, when not in use.

Rationale and Summary:

Treatment creams were observed to be left on top of the linen hamper in the resident common hallways, while not being attended by staff.

The PSW confirmed that staff kept the resident's treatment creams above the linen carts, away from the resident's reach. PSW stated that they obtained the treatment creams from the registered staff at the start of their shift so they could be applied to the residents during care.

The RN explained that treatment creams were given to the PSW staff at the beginning of their shift, so they could apply them during care. RN stated that the PSW would keep the treatment creams above the linen carts so they were out of the resident's reach.

Review of the medication storage policy directed, that required medication are to be locked at all times

when not attended by the nurse.

Failing to ensure that treatment creams were stored in an area that was locked and secured, increased the risk of injury to the resident.

Sources: Observation in the home, Medication storage policy and interview with staff. [194]

This order must be complied with by June 8, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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