Ontario

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

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

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

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


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

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

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 19, 2018 | 2018_591623_0003 | 000194-18, 001415-18 | Complaint |

### Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care Lindsay Nursing Home
240 Mary Street West LINDSAY ON K9V 5K5

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

SARAH GILLIS (623)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): January 23, 24, 25 and 26, 2018**

**The following logs were inspected concurrently:**
**Log# 000194-18 - Critical Incident Report related to an adverse medication reaction requiring transfer to hospital.**
**Log# 001415-18 - Complaint related to staffing and medication errors.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing (DON), Resident Care Co-ordinators (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), the Physician, and residents.**

**In addition, the following were reviewed: clinical medical records, the licensee's internal investigation, staff education and personal files, staffing schedules, and related policies.**

**The following Inspection Protocols were used during this inspection:**
**Medication**
**Personal Support Services**
**Sufficient Staffing**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to develop an interdisciplinary medication management system

that provides safe medication management and optimizes effective drug therapy outcomes for residents who have a specific diagnosis including those who are receiving a specific medication or what is expected of the registered staff when a resident specific testing is below a therapeutic level.

Re: Critical Incident Log # 000194-18

A Critical Incident Report (CIR) was submitted to the Director on a specified date, for an adverse drug reaction which resulted in resident #001 being transferred to the hospital.

The CIR indicated that on a specified date and time resident #001 was discovered by RPN #101 and RPN #100. Resident #001 had received a specific medication 90 minutes prior and had not eaten after the medication was administered.

A review of the clinical record indicated that resident #001 had a specific diagnosis that required the use of a specific medication to manage the diagnosis. A review of the Physician Orders, indicated that the resident was to receive a specified amount of medication before breakfast and lunch, and another specified amount before dinner. The resident was to also receive an additional specific medication at bedtime.

Inspector #623 reviewed the licensee's contracted pharmacy's medication management system titled Medical Pharmacies, The Medication System Policy 3-12 - How to Administer Specified Medications (last reviewed February 2017). This procedure does not include the administration of the specific medication or when the specific test are below the therapeutic level what the registered staff are expected do.

A review of the licensee's Policy effective July, 2010 (reviewed July 2016) titled "Management of a specific condition". The treatment section of this policy includes a direction to staff that for residents with mild to moderate specified conditions, treat with 15 grams of carbohydrate, wait 15 minutes and retest. If a specific test remains below a therapeutic level, then the resident should be retreated. If the resident specific condition is severe than treatment is the same for conscious residents except the initial administration of carbohydrate should be 20 grams. Also, the resident's physician should be notified of all specified episodes requiring treatment.

Review of the specific test monitoring records for resident #001 indicated a result below a therapeutic level on five specified dates in a specific month in 2017.

Review of the progress notes for resident #001 indicated that documentation for the treatment or action for the specified condition could only be found for one identified date. No evidence could be found to indicate that the physician was notified of resident #001’s change in condition.

On January 2, 2018 new orders were received for resident #001 which indicated the resident was to receive a specified amount of an identified medication at bedtime and to hold medication if the specified test was less than a specified level.

Review of the specific test monitoring records for resident #001 indicated that specified test levels were below the identified specific level on twelve occasions in a specified month in 2018, and below the identified therapeutic level on two occasions in the same month. No evidence could be found for the treatment or action for resident #001 on the identified dates, or to indicate that the physician was notified of the change in condition.

A review of the progress notes indicated that on a separate date in 2018, interventions were administered to resident #001 for a specified test result below the therapeutic level. This incident was not recorded on the specific test monitoring record, but was documented in the progress notes. There is no documented evidence that the physician was notified of this event.

During an interview with Inspector #623, RN #107 indicated having never been informed that resident #001 required a specific medication to be held during the two identified months. RN #107 indicated that if a resident required the identified medication to be held for two consecutive days the expectation is that the physician would be informed but there was no policy to indicate this.

During an interview with Inspector #623, RCC #106 indicated that it is the licensee's policy when a resident experiences a specific medical event that requires treatment, the physician is to be notified and documentation in Point Click Care (PCC) should reflect this. The RCC #106 indicated that it is the expectation of the home that the RPN's who administer the medications, will notify the physician if the resident requires a specific medication to be held due to specific test results below a therapeutic level. The RCC indicated not being aware that resident #001 had not received a specified medication at any time, due to specific test result below a therapeutic level. RCC indicated that it is the licensee expectation that the physician would be notified if this occurred.

During an interview with Inspector #623, the physician reviewed the documentation for

resident #001's specific test results for two identified months. The physician indicated not being aware that resident #001 had experienced thirteen instances of specified test results lower than the specified level and medication was held, six instances where the specified test results were within a therapeutic level and the specified medication was held, and five instances where another specific medication was held at bedtime, on one month. The physician indicated also not being aware that during the month prior, specific test records for resident #001 and indicated that there were 28 recorded instances where the resident's specific test results were below the identified level. The physician indicated that the expectation would be that the nurse would make the physician aware after the specified medication was required to be held three times. The physician also indicated never being informed that a specific medication was being held at bedtime. The physician's expectation was to be informed of each occurrence related to the bedtime medication.

The licensee failed to develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents, who have a specific diagnosis including those who are receiving a specific medication or what is expected of the registered staff when a resident specific testing is below a therapeutic level. [s. 114. (1)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).**

**s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences related to the provision of care and safe medication administration practices.

Related to log# 000194-18 and Critical Incident Report (CIR)

A CIR was submitted to the Director on a specified date for an adverse drug reaction that required resident #001 to be transferred to the hospital.

The CIR indicated that on a specific date and time resident #001 was discovered by RPN #101 and RPN #101. Resident #001 had received a specific medication 90 minutes prior, and had not received a meal after the medication was administered.

A review of the CIR indicated in the Long-term Actions section, that the Substitute Decision Maker (SDM) for resident #001 had requested that RPN #100 not provide care to this resident.

Review of the licensee's internal investigation for the CIR indicated an email from the Director of Nursing (DON) to RCC #106 advising the RCC to speak to RPN #100 and inform the RPN the SDM for resident #001 had requested that the RPN not work with resident #001 and to trade units with another RPN or, request that another RPN provide care to resident #001.

A review of the clinical records for resident #001 indicated that on a specified date, RPN #102 was approached by the SDM for resident #001 asking why RPN #100 had been providing care to resident #001 against the SDM and resident's wishes, on three specific dates.

During an interview with Inspector #623, resident #001 indicated that the SDM had met with the DON and requested RPN #100 not provide care to the resident following the CIR. Resident #001 indicated that there has been several days since then, that RPN #100 had provided care to the resident. Resident #001 indicated that the SDM was aware of this and had brought the concern forwards to the DON.

During an interview with Inspector #623, RCC #106 indicated that they had received direction from the DON on a specified date, requesting that the RCC speak to RPN #100 regarding the incident and to inform the RPN not to work with resident #001. RCC #106 indicated that the meeting took place and RPN #100 indicated to have understood the SDM's request.

During an interview with Inspector #623 the DON indicated that resident #001's SDM requested that RPN #100 not work with the resident. The DON indicated that RCC #106 was directed to meet with RPN #100 to inform them of the SDM's wishes regarding resident #001. The DON was not certain if RPN #100 understood that this was to be ongoing. The DON indicated that following the meeting, RPN #100 then was scheduled and did work 3 consecutive shifts with resident #001. The DON indicated that a complaint was received from the SDM regarding this. The DON indicated that a meeting was held with the SDM and there was a new plan going forwards. The DON indicated the SDM seemed satisfied with this plan. The DON indicated that RPN #100 was scheduled to work with resident #001, as an oversight.

The licensee failed to ensure that the plan of care for resident #001 was based on the resident's assessed needs and preferences by continuing to schedule RPN #100 to provide care to resident #001 against the resident and SDM's wishes. [s. 6. (2)]

2. The licensee has failed to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences related to specific medication administration.

Related to log# 000194-18 for Critical Incident Report (CIR)

Resident #001 has a specified diagnosis. The resident also receives a specific treatment at the hospital on specified days. On specified treatment days the morning medications are scheduled to be administered at an earlier time, so that resident #001 is able to attend the appointment. On non-treatment days medications are scheduled to be administered at the routine times.

Review of the Critical Incident Report (CIR) for an adverse medication reaction which required transfer to the hospital, that occurred on a specific date and time when resident #001 was discovered by RPN #101 and RPN #100. The CIR indicated that resident #001 had received a specified medication at a specified time but had not received a meal with it.

Review of the licensee's internal investigation indicated that on a specified date, RPN #100 completed a specified test on resident #001 at a specified time. RPN #100 then administered a specified medication to resident #001. The medication was scheduled to be administered at twenty five minutes later on the eMAR. Resident #001 was asleep in bed at the time the medication was administered as indicated in the clinical records. Resident #001 would usually get up early for breakfast to attend an appointment on that day, but the appointment schedule had changed due to a scheduled holiday. RPN #100 indicated during an interview with the DON that they were aware that resident #001 was not attending an appointment that day, but gave the medication anyway, as it was scheduled to be administered at that specified time on the eMAR. RPN #100 was aware that a meal would not be served until two and a half hours later.

RPN #100 and RPN #101 attended resident #001's room together ninety minutes after the medication was administered and discovered resident #001 to be experiencing an adverse reaction to the medication. RPN #101 documented that resident #001 was unable to respond verbally upon discovery. RPN #101 a specified test and discovered the results to be below an acceptable therapeutic level. RPN #101 followed the licensee's specified protocol with little effect. The resident #001 was not responding and was transferred to hospital.

RPN #100 was unavailable for interview during the inspection.

During an interview with Inspector #623, RPN #101 indicated that after resident #001 had been transferred to hospital, the taped report from RPN #100 was reviewed and it was discovered that resident #001 had received all medications at a specific time and did

not have a scheduled appointment that day. RPN #101 reported this information to RN #107. During the time that RPN #101 was responding to the adverse event that resident #001 was experiencing, RPN #100 never indicated that the resident had received this specific medication ninety minutes prior and had not received a meal yet.

The licensee failed to ensure that the plan of care for resident #001 was based on an assessment of the resident and the resident's needs, related to RPN #100 administering a specified medication at an identified time and not ensuring that resident #001 was provided with food once the medication was administered, thereby resulting in resident #001 experiencing an adverse reaction requiring transfer to the hospital. [s. 6. (2)]

3. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Related to Complaint log #000194-18 and Critical Incident Report (CIR) log #001415-18

Review of resident #001's medication administration records for a specific month, indicated that the residents specified test results were taken and recorded before each meal, every day. On 28 occasions, resident #001's specific test results were below a specified level. The eMAR indicated that medication was held on two of those occasions.

A review of the physician orders for resident #001 indicated that new orders were received on a specific date indicating a specific medication dose at bedtime. New orders also indicated an identified acceptable therapeutic level for resident #001, if the specific test results were below that level, then the specified medication was not to be administered and to be held until later.

Review of resident #001's medication administration records following the new physician order, indicated that specific test results were obtained and on 15 occasions the test results were below the physician ordered acceptable therapeutic level, and the specific medication was documented as held. There were six occasions that the specific test results were within the physician ordered acceptable therapeutic level and the specific medication was documented as held. There were five occasions when the specified medication to be given at bedtime was documented as being held.

Review of the progress notes for resident #001 for a specific two month time period was completed. There were two documented incidents where resident #001 experienced an adverse effect requiring interventions but did not require transfer to hospital. There was no documented evidence to indicate the physician was notified of either event, or that the physician was notified when the residents specific test results were below the acceptable level and the specified medication was held.

During an interview with Inspector #623, RN #107 indicated that they had never been informed that resident #001 required specific medication to be held during the two identified months. RN #107 indicated that if a resident required a specific medication to be held for two consecutive days, it would be the expectation that the physician would be informed but there is no policy to indicate this.

During an interview with Inspector #623, RCC #106 indicated that it is the licensee's policy when a resident experiences an adverse medical event that requires treatment, the physician is to be notified and documentation in PCC should reflect this. The RCC #106 indicated that it is the expectation of the home that the RPN's who administer the medications, will notify the physician if the resident requires a specific medication to be held due to specific test results below therapeutic levels. The RCC indicated not being aware that resident #001 had not been administered specific medications at any time, due to specific test results below therapeutic levels. RCC indicated that the expectation is the physician would be notified of this.

During an interview with Inspector #623, RPN #108 indicated that on three identified dates specific identified medication was held for resident #001 when the specific test results were within an identified therapeutic level, because the RPN was worried that resident #001 consume enough food following the medication administration. RPN #108 indicated not documenting the reason why the specific medication was held, did not notify the RN charge nurse of the concern and did not notify the physician for further directions.

During an interview with inspector #623, RPN #101, indicated that on a specific date and time a specified medication was held for resident #001 was held when the specified test results were within the identified acceptable therapeutic level. RPN indicated that there were several the specified medication was held when the specific test results were below the acceptable therapeutic level as directed in the physician orders. RPN #101 indicated not informing the physician that the specific medication was being frequently held.

During an interview with Inspector #623, the physician indicated not being notified of the adverse medication event when resident #001 was sent to hospital. The physician confirmed that changes were made to the medication orders following that event. The physician reviewed the specific test results records for resident #001 following the medication changes and indicated not being aware that resident #001 had experienced 13 instances of specific test results below the identified acceptable level and a specific medication was held, six instances where the specific test results were within an acceptable therapeutic level and the specified medication was held, and five instances where the bedtime specified medication was held. The physician also reviewed the specific test results records for resident #001 for the month prior to the adverse medication event, and indicated not being made aware that during the specified month there were 28 recorded instances where the resident's specified test results were below the identified therapeutic level. The physician indicated that the expectation would be that the nurse would notify the physician if the specified medication was required to be held three times. The physician also indicated not being informed that the specific bedtime medication was being held.

The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other by failing to document and inform the physician when resident #001's specified test results were below an acceptable therapeutic level, when specific medications were held and when resident #001 experienced adverse medical events that required interventions. [s. 6. (4) (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 by ensuring that the plan of care is provided based on the assessed needs and preferences of the resident and that staff and others involved in the different aspects of care of the resident collaborate with each other, to be implemented voluntarily.***

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**WN #3: 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 has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Resident #001 has specific diagnosis. A review of the physician orders for resident #001 indicated that new orders were received on a specific date indicating a specific medication dose at bedtime. New orders also indicated an identified acceptable therapeutic level for resident #001, if the specific test results were below that level then the specified medication was not to be administered and to be held until later.

Review of the physician orders indicated that resident #001 was to receive a specific test three times daily prior to the administration of a specific medication.

Review of the electronic medication administration records (eMAR) for a specific month, indicated that on six identified dates a specified medication was held when the specific test results were within an identified therapeutic level.

On five specific dates a specified medication was documented as held at bedtime:

Review of the progress notes identified the five dates that the specific bedtime medication was held but there is no documented evidence to indicate that the physician was notified.

During an interview with Inspector #623, RPN #101 indicated that on a specified date, a verbal order was received via phone from the physician for changes to the specific medication orders for resident #001. The new orders indicated that the nurse was to hold the identified medication if the specific test result was below an identified therapeutic level. RPN #101 indicated that on a specific date and time, the identified medication for resident #001 was held when the specific test results were within an acceptable identified therapeutic level and the RPN did not notify the physician.

During an interview with Inspector #623, RPN #108 indicated that they held resident #001's specific identified medication on three separate occasions despite the specific test results being within an acceptable identified therapeutic level. RPN #108 indicated they were worried that resident #001 would not consume enough food if the medication was given. RPN #108 indicated that they did not re-approach the resident #001 after the meal to evaluate if the medication could be given. The RPN indicated that they did not document the reason why the specific medication was held, did not notify the RN charge nurse of the concerns and did not attempt to contact the physician for further directions.

During an interview with Inspector #623, the physician completed a review of the specified test results and medication administration records for an identified month. The physician reviewed the specific test results records for resident #001 following the medication changes and indicated not being aware that resident #001 had experienced 13 instances of specific test results below the identified acceptable level and a specific medication was held each time, six instances where the specific test results were within an acceptable therapeutic level and the specified medication was held, and five instances where the bedtime specified medication was held without an order. The physician indicated that the expectation is the nurse would notify the physician after the specific medication was required to be held three times. The physician also indicated never being informed that the specific identified bedtime medication was being held without an order to do so, and if the RPN was doing this, the physician would expect to be informed.

During an interview with Inspector #623, the Director of Nursing (DON) indicated it is the expectation of the licensee that all medications are administered as prescribed. If the medication cannot be administered as prescribed, it is the expectation that the RN or RPN will document the reason why in the progress notes and inform the physician. The DON indicated that the expectation is the RPN will identify any concerns for residents and bring them forwards to the physician when rounds are being completed, or sooner if the situation warrants it.

The licensee failed to ensure the specific identified medications were administered as prescribed to resident #001. [s. 131. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**Issued on this 18th day of April, 2018**

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

**Original report signed by the inspector.**

Ontario

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

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

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

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

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | SARAH GILLIS (623) |
| **Inspection No. / No de l'inspection :** | 2018_591623_0003 |
| **Log No. / No de registre :** | 000194-18, 001415-18 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Mar 19, 2018 |
| **Licensee / Titulaire de permis :** | Caressant-Care Nursing and Retirement Homes Limited<br>264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9 |
| **LTC Home / Foyer de SLD :** | Caressant Care Lindsay Nursing Home<br>240 Mary Street West, LINDSAY, ON, K9V-5K5 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Butch Ashcroft |

To Caressant-Care Nursing and Retirement Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee is ordered to:

1. Develop an interdisciplinary medication management system to optimize the drug therapy outcomes for residents with specific diagnosis.

2. This interdisciplinary medication management system shall include but is not limited to:
a) the assessment and reassessment of residents with a specific diagnosis by a member of the interdisciplinary team including a process of communication with the physician, RN's, RD and any other clinicians, as appropriate.
b) timely and effective communication of information related to food, fluid and snack intake and specific testing results.
c) clear directions to registered nursing staff on documentation requirements for specific medication administration including when using a range dose.
d) best practices in the management of a specific diagnosis, with a focus on actions to be taken by the interdisciplinary team when specific test results are below a therapeutic level.

3. Communicate the content of the medication management system for residents with a specific diagnosis to all members of the interdisciplinary team, ensuring that all members understand their roles and responsibilities in optimizing drug therapy outcomes for residents with a specific diagnosis.

4. Provide enhanced nursing leadership and play an active role in supporting the management team of the home in implementing this interdisciplinary medication management system through the implementation of an evaluation process to assess the overall effectiveness of the actions taken in response to this compliance order. A written record will be kept of the evaluation process for all members of the interdisciplinary team.

**Grounds / Motifs :**

1. The licensee failed to develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents who have a specific diagnosis including those who are receiving a specific medication or what is expected of the registered staff when a resident specific testing is below a therapeutic level.

Re: Critical Incident Log # 000194-18

A Critical Incident Report (CIR) was submitted to the Director on a specified date, for an adverse drug reaction which resulted in resident #001 being transferred to the hospital.

The CIR indicated that on a specified date and time resident #001 was discovered by RPN #101 and RPN #100. Resident #001 had received a specific medication 90 minutes prior and had not eaten after the medication was administered.

A review of the clinical record indicated that resident #001 had a specific diagnosis that required the use of a specific medication to manage the diagnosis. A review of the Physician Orders, indicated that the resident was to receive a specified amount of medication before breakfast and lunch, and another specified amount before dinner. The resident was to also receive an additional specific medication at bedtime.

Inspector #623 reviewed the licensee's contracted pharmacy's medication management system titled Medical Pharmacies, The Medication System Policy 3-12 - How to Administer Specified Medications (last reviewed February 2017). This procedure does not include the administration of the specific medication or when the specific test are below the therapeutic level what the registered staff are expected do.

A review of the licensee's Policy effective July, 2010 (reviewed July 2016) titled "Management of a specific condition". The treatment section of this policy includes a direction to staff that for residents with mild to moderate specified conditions, treat with 15 grams of carbohydrate, wait 15 minutes and retest. If a specific test remains below a therapeutic level, then the resident should be retreated. If the resident specific condition is severe than treatment is the same for conscious residents except the initial administration of carbohydrate should be 20 grams. Also, the resident's physician should be notified of all specified episodes requiring treatment.

Review of the specific test monitoring records for resident #001 indicated a result below a therapeutic level on five specified dates in a specific month in 2017.

Review of the progress notes for resident #001 indicated that documentation for the treatment or action for the specified condition could only be found for one

identified date. No evidence could be found to indicate that the physician was notified of resident #001's change in condition.

On January 2, 2018 new orders were received for resident #001 which indicated the resident was to receive a specified amount of an identified medication at bedtime and to hold medication if the specified test was less than a specified level.

Review of the specific test monitoring records for resident #001 indicated that specified test levels were below the identified specific level on twelve occasions in a specified month in 2018, and below the identified therapeutic level on two occasions in the same month. No evidence could be found for the treatment or action for resident #001 on the identified dates, or to indicate that the physician was notified of the change in condition.

A review of the progress notes indicated that on a separate date in 2018, interventions were administered to resident #001 for a specified test result below the therapeutic level. This incident was not recorded on the specific test monitoring record, but was documented in the progress notes. There is no documented evidence that the physician was notified of this event.

During an interview with Inspector #623, RN #107 indicated having never been informed that resident #001 required a specific medication to be held during the two identified months. RN #107 indicated that if a resident required the identified medication to be held for two consecutive days the expectation is that the physician would be informed but there was no policy to indicate this.

During an interview with Inspector #623, RCC #106 indicated that it is the licensee's policy when a resident experiences a specific medical event that requires treatment, the physician is to be notified and documentation in Point Click Care (PCC) should reflect this. The RCC #106 indicated that it is the expectation of the home that the RPN's who administer the medications, will notify the physician if the resident requires a specific medication to be held due to specific test results below a therapeutic level. The RCC indicated not being aware that resident #001 had not received a specified medication at any time, due to specific test result below a therapeutic level. RCC indicated that it is the licensee expectation that the physician would be notified if this occurred.

During an interview with Inspector #623, the physician reviewed the

documentation for resident #001's specific test results for two identified months. The physician indicated not being aware that resident #001 had experienced thirteen instances of specified test results lower than the specified level and medication was held, six instances where the specified test results were within a therapeutic level and the specified medication was held, and five instances where another specific medication was held at bedtime, on one month. The physician indicated also not being aware that during the month prior, specific test records for resident #001 and indicated that there were 28 recorded instances where the resident's specific test results were below the identified level. The physician indicated that the expectation would be that the nurse would make the physician aware after the specified medication was required to be held three times. The physician also indicated never being informed that a specific medication was being held at bedtime. The physician's expectation was to be informed of each occurrence related to the bedtime medication.

The licensee failed to develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents, who have a specific diagnosis including those who are receiving a specific medication or what is expected of the registered staff when a resident specific testing is below a therapeutic level. [s. 114. (1)]

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 1 as it related to only one resident. The home had a level 2 compliance history for O.Reg. 79/10, s.114. (1) a Compliance Order is warranted due to the potential for actual harm of residents and the failure to provide safe medication management and effective drug therapy outcomes for residents who have a specific diagnosis. (623)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 18, 2018

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

**Issued on this  19th  day of March, 2018**

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

Ontario

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

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

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

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

**Name of Inspector / Nom de l'inspecteur :** Sarah Gillis

**Service Area Office / Bureau régional de services :** Central East Service Area Office