Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 6, 2019	2019_640601_0023	010985-19, 015158-19, 021379-19	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 on McLaughlin Road
114 McLaughlin Road LINDSAY ON K9V 6L1

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

KARYN WOOD (601)

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): October 31, November 1, 4, 5, 6 and 7, 2019.

The following intakes were completed in this complaint inspection:

Log #015158-19 related to staff qualifications, plan of care and care issues.

Log #010985-19 related to staffing and baths not being completed.

Log #021379-19 related to registered nursing staffing and baths not being completed.

During the course of the inspection, the inspector(s) spoke with the Administrator, the acting Director of Care (acting DOC), Resident Care Coordinator (RCC), Ward Clerk (WC), Registered Nurses (RN), Registered Practical Nurses (RPN), RAI-Coordinator (RAI), Activity Director, Personal Support Workers (PSW), family members and residents.

The Inspector also reviewed residents health care records, the licensee's relevant policies and procedures, staff schedules, and observed the delivery of resident care and services including staff to resident interactions.

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

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in the plan related to diagnostic testing.

A complaint was received by the Director on a specified date related to resident #001 with identified symptoms for a specified period of time. The Substitute Decision Maker (SDM) indicated the resident's identified symptoms were not being managed and they had requested the resident receive an examination that included two specified diagnostic tests.

A review of resident #001's clinical health records, by Inspector #601 identified that resident #001 was transferred to an identified facility on two specified dates for treatment of an identified medical condition.

Review of resident #001's physician orders by Inspector #601 for a specified date, identified the Nurse Practitioner (NP) had ordered for resident #001 to receive two specified diagnostic tests. Record review of the clinical health records by Inspector #601, identified that resident #001 had one of the specified diagnostic test the day after the NP had ordered the test and the second diagnostic test was completed on a specified date that was after the resident was sent to the identified facility for treatment of the identified medical condition.

Inspector #601 reviewed resident #001's progress notes for a specified period of time and the following was documented:

-On a specified date and time, RPN #104 documented that resident #001's SDM was inquiring about resident #001 having identified symptoms, for a specified period of time. Resident #001's SDM requested that some test be completed to rule out medical issues or determine if the resident was experiencing a specified symptom. According to the progress note, the NP ordered some other specified medical tests and the two specified diagnostic tests. The NP also recommended that resident #001 receive a specified medication to manage the resident's identified symptoms. RPN #104 documented that resident #001's SDM agreed to the tests and the specified medication.

-On a specified date and time, RPN #104 documented that resident #001's SDM had phoned inquiring if the physician had ordered the second specified diagnostic test. RPN #104 documented the SDM was made aware the second specified diagnostic test had been ordered for resident #001.

-On a specified date and time, RPN #121 documented that resident #001's SDM had delivered resident #001's specified medication.

-On a specified date and time, RN #105 documented that resident #001 had been experiencing specified symptoms throughout the day and the resident's SDM was concerned that resident #001's second specified diagnostic test had not been completed. Resident #001 was transferred to the identified facility for assessment.

-On a specified date and time, Agency RPN #115 documented that resident #001 had reported a specified symptom intermittently throughout the shift and the resident's specified symptom worsened, at a specified time.

-On a specified date and time, Agency RPN #115 documented that during medication count it was discovered that resident #001 did not receive their scheduled specified medication.

-On a specified date and time, RPN #123 documented that resident #001 had returned from the identified facility. RPN #123 also documented the resident had received a specified treatment with good results while in the identified facility. According to the progress note, the results of resident #001's first specified diagnostic test were found and there was no indication the second specified diagnostic test had been completed. RPN #123 documented that resident #001's SDM wanted to know the reason resident #001's second specified diagnostic test had not been completed, as ordered on a specified date. RPN #123 documented that resident #001's SDM discussed this concern with the RCC.

-On a specified date and time, RPN #121 documented the identified facility was sent a fax to obtain an appointment for resident #001's second specified diagnostic test.

-On a specified date and time, the physician documented they had a discussion with resident #001's SDM and the SDM's concern was that resident #001 had a specified symptom, that had not been addressed since the end of an identified month. The resident's SDM was also concerned the report from the identified facility indicated the resident required a specified treatment for a medical condition. Resident #001's SDM also informed the physician the identified facility had told them the reason for the specified symptom was the resident had a specified condition. The Physician documented they explained to resident #001's SDM that resident #001 had been assessed for the specified condition. Resident #001's treatment included two specified medication, the administration of a specified Medical Directive and the first specified

diagnostic test. The Physician also documented that resident #001's second specified diagnostic test was deferred by the physician because the resident seemed to have improved.

-On a specified date and time, RPN #111 documented that resident #001's was sent to the identified facility for a specified symptom at the request of the resident's SDM and the physician. RPN #111 also documented that resident #001 had the second specified diagnostic test completed in the morning.

-On a specified date and time, RPN #111 documented the recommendation from the identified facility was to give resident #001 a specified treatment when reporting the specified symptom.

Review of resident #001's physician orders for a specified period of time, by Inspector #601 and there was no documentation to indicate that resident #001's second specified diagnostic test had been deferred by the physician.

During an interview on a specified date, RPN #104 indicated to Inspector #601 they had discussed resident #001's second specified diagnostic test with resident #001's physician. RPN #104 further indicated the resident's physician had agreed to arrange for their office to book resident #001's second specified diagnostic test.

The licensee did not ensure the care set out in the plan of care for resident #001 was provided to the resident as specified in the plan related to the NP ordered for the resident to receive the second specified diagnostic test on a specified date and there was a delay in the test being completed.

2. The licensee has failed to ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in the plan related to diet.

Review of resident #001's physician orders for a specified date, by Inspector #601 identified the physician had ordered for resident #001 to receive a specified diet.

Review of resident #001's eating section of their written plan of care, by Inspector #601 identified the resident's diet was not the specified diet that was ordered by the physician, on the specified date.

During an interview on a specified date, Dietitian #107 indicated to Inspector #601, they

had not received a diet referral on a specified date, when the physician ordered for the resident to receive the specified diet.

The licensee did not ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in the plan related to the specified diet. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care for resident #001 is provided to the resident as specified in the plan related to diagnostic testing and diet, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff, was on duty, and present at all times unless there is an allowable exception to this requirement.

According to O. Reg. 79/10, s. 45 (1) (2) ii, The following are the exceptions to the requirement that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, as required under subsection 8 (3) of the Act:

For homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds,

ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met, a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if,

(a)the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, and

(b) a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home. O. Reg. 79/10, s. 45 (1).

Ontario Regulation 79/10 section 45. (2) indicates that "emergency" means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the long-term care home.

The Director received an anonymous complaint on a specified date regarding twenty four hour nursing coverage, staffing and residents not receiving their scheduled bath.

Caressant Care on McLaughlin Road is a 96 bed home.

Inspector #601 reviewed the licensee's staffing schedule for registered nurses and the RN coverage provided by the Director of Care and the Administrator for a specified period of time:

There was no Registered Nurse (RN) who was an employee of the licensee and a member of the regular nursing staff or pursuant to a contract or an agreement between the nurse and the licensee present in the home for five specified days for two and a half hours, six specified days for twelve hours and on two specified days for seven hours.

During separate interview on a specified date, RPN #104 and Ward Clerk #118 both indicated to Inspector #601, that they had worked some shifts, when there was not an RN working in the home.

During separate interviews on a specified date, the Administrator and Ward Clerk #118 indicated to Inspector #601, that when an RN was not able to work due to illness or vacation or be replaced by an RN, an RPN would work the RN's scheduled shift.

During an interview on a specified date, Ward Clerk #118 indicated to Inspector #601 that for a specified period of time, the licensee did not have an RN on duty on the above dates and the DOC or Administrator were available by telephone or were working, on the specified dates.

During an interview on a specified date, the Administrator indicated to Inspector #601 that there had been days when RN hours were not covered due to illness or vacation. The Administrator confirmed that for the specified period of time the licensee did not have an RN on duty on the specified dates. The Administrator confirmed that on the identified dates for the specified period of time, the registered nurses were not available to work due to vacation time and the home did not have at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty.

The licensee has failed to comply with r. 45 (1) (2) ii of O. Reg. 79/10, whereby the licensee did not meet the exceptions to the requirement that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times as required under subsection 8 (3) of the Act. [s. 8. (3)]

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 at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff, is on duty, and present at all times unless there is an allowable exception to this requirement, to be implemented voluntarily.

WN #3: 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 has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 114 (2) the licensee was required to ensure that written policies and protocols were developed for the medication management system to ensure the accurate dispensing and administration of all drugs used in the home.

Specifically, staff did not comply with the licensee's Pharmacy Policy and Procedure Manual for Long Term Care Homes. "The Medication Pass" last revised on a specified date, that was part of the licensee's policies developed for the medication management system. This policy directed registered staff to chart the administration of PRN medications on the Medication Administration Record (MAR), the resident progress note, on an "Individual PRN Administration Record" or on the reverse of the paper MAR, as per home policy.

A complaint was received by the Director on a specified date related to resident #001 with identified symptoms for a specified period of time. The Substitute Decision Maker (SDM) indicated the resident's identified symptoms were not being managed and they had requested the resident receive an examination that included two specified diagnostic tests.

A review of resident #001's clinical health records, by Inspector #601 identified that resident #001 was transferred to an identified facility on two specified dates for treatment of an identified medical condition.

Inspector #601 reviewed the Medical Directives for resident #001's specified reason. The Medical Directives prescribed for resident #001 for a specified period of time included four specified medication that were to be administered, as required for the specified reason on day two, three, four and five. The Medical Directives further directed to notify the physician on day five, if the specified medications had not been effective.

Review of resident 001's Point of Care (POC) documentation for a specified period of time related to the specified reason identified that on thirty-eight days the resident required the Medical Directives, for the specified reason.

A review of resident #001's Medication Administration Record (MAR) and POC documentation related to the specified reason for a specified period of time by Inspector #601, identified the day two specified Medical Directive was not utilized to administer resident #001's specified medication, as prescribed on fourteen specified dates.

Review of resident #001's MAR and POC documentation related to the specified reason for a specified period of time by Inspector #601, identified the day three specified Medical Directive was not utilized to administer resident #001's specified medication, as prescribed on six specified dates.

Review of resident #001's MAR and POC documentation related to the specified reason for a specified period of time by Inspector #601, identified the day four specified Medical Directive was not utilized to administer resident #001's specified medication, as prescribed on two specified dates.

During separate interviews on specified dates, RPN #104, RPN #121, RPN #117 and RPN #111 indicated to Inspector #601 the registered staff on the night shift would create a specified list of residents who required the specified Medical Directives for day two, three, four and five. The day shift would follow the Medical Directives for day two and three, the night shift would follow the Medical Directives for day four and five.

During a telephone interview on a specified date, RPN #121 indicated to Inspector #601 they didn't utilize the specified Medical Directives very often for resident #001 and they would hold off on giving the resident's specified medication, for a specified reason. RPN #121 indicated they would usually sign on the resident's MAR if they had administered the medication for the Medical Directives. RPN #121 further indicated sometimes they would get busy and may forget to sign on the MAR to indicate the resident received the medication. RPN #121 indicated they did not notify the physician if the resident did not

receive the medication, as outlined in the Medical Directives for the specified reason.

During an interview on a specified date, RPN #104 indicated to Inspector #601 that they would usually sign for the Medical Directives on the resident's MAR if they had administered the medication for the specified reason. RPN #104 further indicated sometimes they would get busy and may forget to sign on the MAR to indicate the resident received the medication. RPN #104 further indicated they did not notify the physician, if the resident did not receive the medication as outlined in the Medical Directives for the specified reason.

The licensee did not ensure registered staff administered resident #001's medication as prescribed in the Medical Directives for the specified reason or they did not document the administration of PRN specified medications on resident #001's MAR when administered, as directed in the licensee's Pharmacy Policy and Procedure Manual for Long Term Care Homes, "The Medication Pass" and the licensee's policies developed for the medication management system was 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 registered staff chart the administration of PRN medications on resident #001's MAR as directed in the licensee's Pharmacy Policy and Procedure Manual for Long Term Care Homes, "The Medication Pass" and the licensee's policies developed for the medication management system are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001, #002 and #003 were bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths.

The Director received an anonymous complaint on two specified dates regarding twenty four hour nursing coverage, staffing and residents not receiving their scheduled bath.

Related to resident #001:

Review of resident #001's clinical health record by Inspector #601, identified the resident preferred a tub bath and their bath was scheduled for twice a week.

Inspector #601 reviewed resident #001's Point of Care (POC) Documentation Survey Report for a specified period of time. There was no documentation to indicate that resident #001 had received their scheduled bath on six specified dates or that the resident was provided with an alternate bath. [s. 33. (1)]

2. Related to resident #002:

Review of resident #002's clinical health record by Inspector #601, identified the resident preferred a tub bath and their bath was scheduled for twice a week.

Inspector #601 reviewed the POC Documentation Survey Report for resident #002 for a specified period of time. There was no documentation to indicate that resident #002 had received their scheduled bath on eight specified dates or that the resident was provided with an alternate bath. [s. 33. (1)]

3. Related to resident #003:

Review of resident #003's clinical health record by Inspector #601, identified the resident preferred a tub bath and their bath was scheduled for twice a week.

Inspector #601 reviewed the POC Documentation Survey Report for resident #003 for a specified period of time. There was no documentation to indicate that resident #003 had received their scheduled bath on two identified dates or that the resident was provided with an alternate bath.

During separate interviews on specified dates, PSW #106, PSW #119, PSW #120, RPN #106, RPN #104 and RCC #102 indicated to Inspector #601, there were occasions when PSWs worked below the scheduled staffing complement. They further indicated that when working with less PSWs, the resident's scheduled baths on days and evenings were not always completed and the residents were not always provided with an alternate bath.

During an interview on a specified date, the acting Director of Care (acting DOC) indicated to Inspector #601 that a process had been put into place for residents to receive an alternate bath when their scheduled bath was missed due to staff working below staffing complement. The acting DOC further indicated, they were not aware residents were not receiving their scheduled bath and they relied on the registered staff to reschedule the resident's baths when missed.

The licensee did not ensure that resident #001, #002 and #003 were bathed, at a minimum, twice a week by the method of his or her choice. [s. 33. (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 all residents are bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, to be implemented voluntarily.

WN #5: 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 were administered to residents #001, #004 and #005 in accordance with the directions for use specified by the prescriber.

A complaint was received by the Director on a specified date related to resident #001 had identified symptoms for a specified period of time. The Substitute Decision Maker (SDM) indicated the resident's identified symptoms were not being managed and they had requested the resident receive an examination that included two specified diagnostic tests.

Review of resident #001's physician orders by Inspector #601 identified that resident #001 had three specified medication ordered for a specified time.

Review of resident #001's Medication Administration Record (MAR) for a specified period of time identified resident #001 did not receive their prescribed specified medication on thirty-nine specified dates. RPN #104 documented on the MAR that resident #001 was sleeping when the specified medication was not administered to the resident, as prescribed.

Review of resident #001's MAR for a specified period of time identified resident #001 did not receive their prescribed specified medication on a specified date and time. Review of resident #001's progress notes for the specified date identified that Agency RPN #115 documented they realized at the end of their shift that they had forgotten to administer resident #001's specified medication, as prescribed.

Review of resident #001's MAR for a specified period of time by Inspector #601, identified resident #001 did not receive their prescribed specified medication on eighteen specified dates. RPN #104 documented on the MAR that resident #001 was sleeping when the specified medication was not administered to the resident, as prescribed.

During an interview on a specified date, RPN #104 indicated to Inspector #601 they had not notified the resident's physician when they held resident #001's two specified medications when they were sleeping. RPN #104 further indicated that they should have spoken to the physician about the resident sleeping at the identified time and informed the physician that resident #001 wasn't receiving the prescribed medication.

The licensee did not ensure that resident #001's prescribed specified medication was administered to the residents in accordance with the directions for use, as specified by the prescriber.

2. The licensee has failed to ensure that drugs were administered to residents #001 in accordance with the directions for use specified by the prescriber related to a specified medication.

Review of resident #001's physician orders by Inspector #601 for a specified date identified the Nurse Practitioner (NP) had prescribed for resident #001 to receive a specified medication.

Review of resident #001's Medication Administration Record (MAR) for a specified period of time identified that resident #001 received their first dose of a specified medication thirty-six days after the medication had been prescribed.

During a telephone interview, RPN #121 indicated to Inspector #601, the NP had prescribed for resident #001 to receive the specified medication on a specified date. RPN #121 further indicated the licensee's pharmacy did not provide this medication and the resident's SDM was responsible to complete the application form and submit the form to the supplier of the medication. RPN #121 indicated they were working when the NP prescribed the specified medication for resident #001 and could not recall providing the resident's SDM with the application form to be completed. RPN #121 further indicated they had never ordered the specified medication and were not sure of the process when the NP had prescribed the medication.

During an interview, RPN #104 indicated to Inspector #601 that the NP had prescribed for resident #001 to receive the specified medication on a specified date. RPN #104 further indicated the licensee's pharmacy did not provide this medication and the resident's SDM was responsible to complete the application form and submit the form to the supplier of the medication. RPN #104 indicated to Inspector #601 that resident #001's SDM had approached them to ask why the medication had not been started. RPN #104 indicated they found the application form in the resident's chart, called the supplier of the medication and realized the resident's SDM would need to submit the forms. RPN #104 indicated they assisted the resident's SDM with submitting the forms and the specified medication arrived at the home a few days later.

During a telephone interview, RCC #102 indicated to Inspector #601 the application form for resident #001's specified medication was signed by the resident's SDM on a specified date and that it was not clear when the form had been faxed to the supplier of the medication. RCC #102 further indicated that resident #001's SDM had approached them

on a specified date, after the resident was receiving the specified medication. RCC #102 indicated resident #001's SDM didn't understand the reason for the delay in obtaining the specified medication. RCC #102 also indicated, the specified medication was to be purchased and received by the SDM. RCC #102 indicated that they were not aware of the delay in the medication being ordered until the SDM approached them, on a specified date.

The licensee did not ensure that drugs were administered to residents #001 in accordance with the directions for use specified by the prescriber related to the NP prescribed for the resident to receive specified medication and the resident received the first dose of the medication thirty-six days after the medication had been prescribed, when the medication was received in the home.

3. Related to resident #004:

Non-compliance was identified while inspecting Log #015158-19. The scope was expanded to include resident #004.

The licensee has failed to ensure that drugs were administered to residents #004 in accordance with the directions for use specified by the prescriber related to a specified medication.

Inspector #601 reviewed the licensee's Pharmacy Medication Incident Notifications for a specified period of time. The Medication Incident Notification Report completed by RPN #110 indicated that on a specified date, resident #004's physician had prescribed a specified medication, starting on a specified date. On a specified date, sixteen days later it was discovered that resident #004's specified medication was not in resident #004's medication strip package.

Review of resident #004's MAR and physician orders, by Inspector #601 for a specified period of time. On a specified date, resident #004's physician had prescribed the specified medication.

Inspector #601 reviewed resident #004's progress notes for a specified period of time and identified the following:

-On a specified date and time, RPN #111 documented resident #004 did not have the specified medication in their medication strip package and the pharmacy was notified by

fax.

-On a specified date and time, RPN #110 documented that on a specified date, resident #004's physician ordered the specified medication. The physician order was entered onto the resident's eMAR and the medication was not in the resident's medication strip packs.

-On a specified date and time, RPN #112 documented they received a fax from the pharmacy requesting for resident #004's physician order for the specified medication to be faxed, as the pharmacy indicated they had not received the physician order for resident #004's specified medication, on the specified date.

During an interview, RPN #112 indicated to Inspector #601 they had documented resident #004's specified medication was administered on nine specified dates. RPN #112 indicated that on a specified date they discovered resident #004's specified medication was not in their medication blister pack. They further indicated they had forgotten to notify the Pharmacy, SDM and physician about the specified medication not being in the medication blister pack, on two specified dates. RPN #112 indicated they informed RPN #110, Pharmacy, physician and the resident's Substitute Decision Maker (SDM) about the specified medication not being in the resident's medication strip pack, three days later on a specified date. They further indicated the pharmacy reported they had not received the physician order for resident #004 to receive the specified medication, when prescribed by the physician.

Review of resident #004's MAR by Inspector #601, identified that RPN #113 had documented they had administered resident #004's specified medication on three specified dates, when the pharmacy had not provided the medication.

Review of resident #004's MAR by Inspector #601, identified that RPN #114 had documented they had administered resident #004's specified medication on two specified dates, when the pharmacy had not provided the medication.

Review of resident #004's MAR by Inspector #601, identified that RPN #115 had documented they had administered resident #004's specified medication on one specified date, when the pharmacy had not provided the medication.

During an interview, RCC #102 indicated to Inspector #601, the pharmacy had not provided resident #004's specified medication for the specific period of time and the specified medication was not administered to resident #004, as prescribed by the

physician, for the specified period of time.

The licensee did not ensure that resident #004's prescribed specified medication was administered to residents #004 in accordance with the directions for use, as specified by the prescriber.

4. Related to resident #005:

Non-compliance was identified while inspecting Log #015158-19. The scope was expanded to include resident #005.

The licensee has failed to ensure that drugs were administered to residents #005 in accordance with the directions for use specified by the prescriber related to a specified medication.

Inspector #601 reviewed the licensee's Pharmacy Medication Incident Notifications for a specified period of time. The Medication Incident Notification Report completed by RN #109 indicated that resident #005 did not receive a specified medication as prescribed, on a specified date and time.

Review of resident #005's Medication Administration record (MAR) by Inspector #601, indicated resident #005's physician prescribed the specified medication. Record review of resident #005's MAR identified that on the specified date and time, resident #005's specified medication was not signed as administered and directed to see nurse's progress notes.

Inspector #601 reviewed resident #005's progress note on the specified date and time, documented by RN #109 indicating that resident #005 did not receive specified medication on a specified date and time, as scheduled.

During separate interviews, RN #109 and RN #105 indicated to Inspector #601 they were completing the medication count on a specified date and time, when it was discovered that RN #109 had not administered resident #005's specified medication on the specified date and time, as prescribed by the physician.

During an interview, RCC #102 indicated to Inspector #601, that resident #005 had not received their prescribed specified medication, on the specified date and time.

The licensee did not ensure that drugs were administered to residents #005 in accordance with the directions for use specified by the prescriber related a specified medication. [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 to ensure that drugs are administered to residents #001, #004 and #005 in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: 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 has failed to ensure that every medication incident involving a resident and every adverse drug reaction was (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and (b) reported to the resident, the resident's SDM, 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.

A complaint was received by the Director on a specified date related to resident #001 had identified symptoms for a specified period of time. The Substitute Decision Maker (SDM) indicated the resident's identified symptoms were not being managed and they had requested the resident receive an examination that included two specified diagnostic tests.

Related to resident #001:

Review of resident #001's Medication Administration Record (MAR) for a specified period of time identified resident #001 did not receive their prescribed specified medication on a specified date and time. Review of resident #001's progress notes for the specified date identified that Agency RPN #115 documented they had forgotten to administer resident #001's specified medication on the specified date and time, as prescribed. According to the progress note, the charge nurse was made aware of the medication incident.

During separate interviews, the Administrator and RCC #102 indicated they were not aware of resident #001 not receiving their scheduled specified medication on the specified date and time, as prescribed. They both indicated a Pharmacy Medication Incident Notification Report was not completed by Agency RPN #115 and they were not aware of any further action being taken to notify resident #001's Substitute Decision Maker (SDM), the physician or Nurse Practitioner.

There was no documented evidence of the immediate actions taken to assess and maintain the resident's health or documentation to indicate that resident #001 was monitored for any adverse reaction, or that the pharmacy, resident #001's SDM, physician, and the Director of Care (DOC) were notified when resident #001 had not received their scheduled specified medication, on the specified date and time.

The licensee did not ensure that every medication incident involving a resident was documented to include the immediate actions taken to assess resident #001, maintain

the resident's health, monitored for any adverse reaction, or that the pharmacy, resident #001's SDM, physician, and the DOC were notified when resident #001 had not received their scheduled specified medication, on the specified date and time. [s. 135. (1)]

2. The licensee has failed to ensure that (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed (b) corrective action was taken as necessary, and (c) a written record was kept of everything required under clauses (a) and (b).

Related to resident #004:

Non-compliance was identified while inspecting Log #015158-19. The scope was expanded to include resident #004.

Inspector #601 reviewed the Medication Incident Notification Report completed by RPN #110 on a specified date, resident #004's physician had prescribed a specified medication, starting on a specified date. On a specified date, sixteen days later it was discovered that resident #004's specified medication was not in resident #004's medication strip package and the resident did not receive the medication, as prescribed for a specified period of time. According to the medication Incident Notification Report the pharmacy had not received resident #004's physician order for the specified medication, when the medication had been prescribed by the physician and the pharmacy did not include the medication in the resident's medication strip packages.

Inspector #601 reviewed resident #004's MAR and identified that RPN #112, RPN #113, RPN #114 and RPN #115 had been working when resident #004 did not receive their specified medication due to the medication not being in the medication strip packages, as prescribed for a specified period of time.

During separate interviews, the Administrator and RCC #102 indicated to Inspector #601 that no follow up or corrective action was taken with RPN #112, RPN #113, RPN #114 and RPN #115 regarding the specified medication not being administered to resident #004, due to the medication not being in the resident's medication strip packages for the specified period of time.

There was no documented evidence the medication incident involving resident #004 was reviewed, analyzed and that corrective action was taken when resident #004's prescribed specified medication was not administered, as prescribed when the medication was not

in the resident's blister pack for the specified period of time.

The licensee did not ensure a medication incident involving resident #004 was reviewed, analyzed and that corrective action was taken when resident #004's prescribed specified medication was not administered, as prescribed when the medication was not in the resident's blister pack for the specified period of time. [s. 135. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction are (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 SDM, 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; and to ensure that (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed (b) corrective action was taken as necessary, and (c) a written record was kept of everything required under clauses (a) and (b), to be implemented voluntarily.

Issued on this 12th day of December, 2019

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

Original report signed by the inspector.