Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 24, Aug 15, 2017	2016_229213_0035	029609-16, 031470-16	Critical Incident System

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 WOODSTOCK NURSING HOME
81 FYFE AVENUE WOODSTOCK ON N4S 8Y2

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

RHONDA KUKOLY (213), MARIAN MACDONALD (137), MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 5, 28, 31, November 1-4, 8-10, 14-18, 29, 30, December 1, 2, 5-8, 12-16, 19, 2016, January 3-6, 9 -13, 16-20, 24, 26, 31, February 1-3, 6-10,13-17, 21-24, 28, March 1-3, 6, 7, 2017

The following critical incidents are included in this inspection:
Log #029609-16, critical incident #2636-000027-16 and log #031470-16, critical incident #2636-000007-13

This inspection was completed concurrently while in the home completing other inspections including:
Inspection #2016_229213_0038: Log #022711-16 related to orders issued as a result of a critical incident inspection log #018577-16, inspection #2016_258519_0007, and log #033528-16 related to orders issued as a result of the Resident Quality Inspection log #002290-16, inspection #2016_326569_0021

Inspection #2016_303563_0042: Log #033550-16, critical incident #2636-000032-16

Inspection #2016_255633_0025: Log #033908-16, critical incident #2636-000038-16 and log #034107-16, infoline #IL-48359-LO

Inspection #2017_605213_0001: Log #033930-16, complaint Infoline #IL-48314-LO

Inspection #2017_508137_0001: Log #002462-17, complaint Infoline #IL-49142-LO

Inspection #2016_229213_0039:
Log #004840-16, critical incident #2636-000006-16
Log #008948-16, critical incident #2636-000010-16
Log #015639-16, critical incident #2636-000013-16
Log #017131-16, critical incident #2636-000016-16
Log #021944-16, critical incident #2636-000021-16
Log #027293-16, critical incident #2636-000013-16
Log #027733-16, critical incident #2636-000024-16
Log #035063-16, critical incident #2636-000040-16
Log #033028-16, critical incident #2636-000030-16
Log #033029-16, critical incident #2636-000031-16
Log #000464-17, critical incident #2636-000001-17
Log #000590-17, critical incident #2636-000002-17
Log #000857-17, critical incident #2636-000007-15
Log #001129-17, critical incident #2636-000003-17
Log #001413-17, critical incident #2636-000005-17
Log #001869-17, critical incident #2636-000007-17

During this inspection, as per section 302 of Ontario Regulation 79/10, requirements under a previous Act were inspected. The Long-Term Care Homes Program Manual Standards and Criteria were part of an agreement made under the

Nursing Homes Act and in effect until July 1, 2010. The following Long-Term Care Homes Program Manual Standards and Criteria were found to be unmet.

WN #14:
The Long-Term Care Homes Program Manual Standards and Criteria M3.7 stated: Unusual occurrences shall be reported according to Ministry policy. The Ministry of Health and Long- Term Care Unusual Occurrence Report required homes to indicate the type of unusual occurrence including "unusual or accidental death".

Resident health care records were reviewed in the home. A resident was admitted to the home and passed away 19 days after being admitted to the home. The "Institutional Patient Death Record" was faxed to the Office of the Chief Coroner. The record indicated "Accidental death?", and the box "YES" was checked, as well as "Is the death both sudden and unexpected?" and the box "YES" was checked.

The home's clinical records and the Ministry of Health and Long Term Care Report archived files were reviewed for a year for the home and no unusual occurrence report was found related to a sudden and unexpected or accidental death of this resident.

In an interview with the Director of Nursing (DON), the DON was unable to recall if an unusual occurrence report had been completed related to the sudden and unexpected death or accidental death of this resident and was not able to produce an unusual occurrence report, related to the death of this resident.

The Long-Term Care Homes Program Manual Standards and Criteria M3.7, unusual occurrences shall be reported according to Ministry policy, was not met related to the unexpected death of a resident.

WN # 15:
The Long Term Care Homes Program Manual Standards and Criteria M3.7 stated: Unusual occurrences shall be reported according to Ministry policy. The Ministry of Health and Long- Term Care Unusual Occurrence Report required homes to indicate the type of unusual occurrence including "medication/treatment error resulting in hospital admission".

A Caressant Care Internal Resident Incident Report was documented by a registered nursing staff member, in Point Click Care, for a resident related to a

medication incident. The registered staff called the physician on call about orders for treatment who told the registered staff that a nurse had called them about a medication incident. The incident report was signed by the resident's physician, by the Director of Nursing (DON), the Administrator, and the registered staff. The section indicating "MOH Unusual occurrence report completed" was left blank and unchecked.

The home's clinical records and the Ministry of Health and Long Term Care Report archived files were reviewed for a year for the home, and no unusual occurrence report was found related to a medication incident for a resident. Progress notes documented by a registered nursing staff member indicated the resident had a decline in condition. The registered staff called the doctor to receive orders on treatment and the doctor told the registered staff that another registered staff from Caressant Care had called earlier to inform the doctor of a medication incident, the registered staff checked for any incident reports and found none completed. The registered staff documented that they were not informed of any medication incidents at shift change. There were no progress notes documented for the shift of the reported medication incident and there were no medication incidents documented for this resident on that date. The following day, progress notes stated the resident was to be admitted to the hospital and received treatment for several days in hospital.

In an interview with the DON, the DON was unable to recall if an unusual occurrence report had been completed related to the medication incident for the resident. The DON said that because the "MOH unusual occurrence report completed" was blank and unchecked, that meant that they either forgot to check it off or didn't complete one. The home was not able to produce an unusual occurrence report, related to a medication incident for this resident.

The Long-Term Care Homes Program Manual Standards and Criteria M3.7, unusual occurrences shall be reported according to Ministry policy, was not met related to the medication incident and hospitalization of a resident.

WN #16:
The Long-Term Care Homes Program Manual Standards and Criteria R8.1 stated: "All medication errors and adverse drug reactions shall be reported promptly to the director of nursing, prescriber, and pharmacist according to established policy and procedure and specific follow-up action shall be taken".

A Caressant Care Internal Resident Incident Report was documented in Point Click Care by a registered staff member, for a resident, for a medication incident that occurred. The registered staff called the doctor on call about orders for treatment who told the registered staff that another registered staff had called the doctor earlier about a medication incident. The incident report was signed by the resident's physician, by the Director of Nursing, the Administrator, and a registered staff. The section indicating "MOH Unusual occurrence report completed" was left blank and unchecked.

In an interview with the DON, the DON was unable to recall if any follow up had been completed related to the medication incident for this resident. The home was not able to produce any documentation or evidence of any follow up actions taken related to the medication incident for this resident.

In an interview with a Consultant Pharmacist, who provided services to the home at that time, they said that the home did not report all medication incidents to the pharmacy. The Pharmacist said that they were notified of pharmacy errors, but nursing errors were dealt with internally by the home.

The Long-Term Care Homes Program Manual Standards and Criteria R8.1, all medication errors and adverse drug reactions shall be reported promptly to the director of nursing, prescriber, and pharmacist according to established policy and procedure and specific follow- up action shall be taken, was not met related to the medication incident for a resident.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, the Administrator, the Director of Nursing, the Acting Director of Nursing, previous Administrators, previous Directors of Care, previous Assistant Directors of Nursing, previous Resident Care Coordinators, two Resident Care Coordinators, Regional Coordinators, the Vice President of Operations, the Vice President of Human Resources, the Corporate Communications Manager, a Corporate Executive Assistant, the Corporate Environmental Services Consultant, Consultant Pharmacists, a Pharmacy Clinical Lead, Physicians, Registered Nurses, Registered Practical Nurses, the Food and Nutrition Manager, a Registered Dietitian, a Program Manager, an Occupational Therapist, a Physiotherapist, a Physiotherapy Assistant, an Ontario Nurses Association Attorney, Personal Support Workers, an Administrative Assistant, a Scheduling Clerk, Ward Clerks,

Maintenance staff, Housekeeping staff, family members, residents.

The Inspectors also observed resident care and medication practices and administration. The Inspectors reviewed electronic and paper health records, incident reports, education records, employee files, meeting minutes, complaint records, policies and procedures, program evaluations, and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication
Reporting and Complaints
Sufficient Staffing
Training and Orientation

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of a missing or unaccounted for controlled substance.

Medication incident reports were reviewed in the home and the following incidents were noted:
•On two specified dates, medication incident reports were completed indicating that one tablet of an identified controlled substance medication was missing for two identified residents. The "Unusual Occurrence Report" completed box was not checked on either report. The medication incident reports were signed by the Director of Nursing (DON).

The Ministry of Health and Long Term Care (MOHLTC) Critical Incident (CI) Reporting System was reviewed. There were no reports of missing or unaccounted for controlled substance at that time.

In an interview with the DON and the Acting Administrator, the DON and the Acting Administrator said that they were aware of the incidents and were unsure as to why they were not reported to the Director.

The licensee failed to inform the Director of the missing or unaccounted for controlled substance. [s. 107. (3) 3.] (213)

2. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of a medication incident or adverse drug reaction in

respect of which a resident was taken to hospital.

Medication incidents reported in Point Click Care and clinical records for two residents were reviewed. A medication incident report stated medications for one resident were documented on the electronic medication administration record (eMAR) as administered to the resident, but were found intact in the strip package in the medication cart the following shift. The medication for another resident with the same surname as the first resident were found missing from the strip packaging in the medication cart that same day.

Progress notes for the second resident stated that the expressed that they were not feeling well and felt a little off. When assessed by a registered staff, the resident requested to go to the hospital for assessment and was transferred to hospital. Resident returned to the home the following day. The Emergency Record included documentation that the home suspected medication administration error.

The home's internal investigation records stated the incident had been followed up with the registered staff involved, for failing to give the first resident their medication as prescribed, as well as failing to document and follow up on the resident's condition in detail. The Director of Nursing (DON) indicated that if the registered staff had audited and checked, they would have seen that the resident was given the wrong medication.

The Ministry of Health and Long Term Care (MOHLTC) Critical Incident (CI) Reporting System was reviewed. There were no CI reports related to a medication incident involving this resident.

In an interview, the DON said a CI report was not submitted to the MOHLTC. The licensee failed to inform the director no later than one business day after the occurrence of a medication incident in respect of which the resident was taken to hospital.

The severity of this non-compliance is minimal risk and the scope is wide spread. The home does not have a history of non-compliance in this subsection of the legislation. [s. 107. (3) 5.] (137)

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 Director is informed of a missing or unaccounted for controlled substance, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacist and the pharmacy service provider and a registered dietitian who is a member of the staff of the home, met quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The licensee failed to ensure that a quarterly evaluation of the medication management system included identified and implemented changes to improve the system in accordance with evidence- based practices and, if there were none, in accordance with prevailing practices.

The licensee failed to ensure that a written record was kept of the results of a quarterly evaluation or any changes that were identified or implemented as a result of the quarterly evaluation.

In an interview with the Medical Director, they said that they had been providing service to the home for many years and had not participated in any Medication Management System program evaluations.

In an interview with an Administrator, the Administrator said that they had not participated in any Medication Management System program evaluations.

In an interview with a Director of Nursing (DON), the DON said that they had not participated in any Medication Management System program evaluations.

In an interview with three current and previous Consultant Pharmacists, the Pharmacists said that they had not participated in any Medication Management System program evaluations.

The home was not able to produce any documentation of quarterly evaluations of the medication management system, or changes that were identified or implemented as a result of a quarterly evaluation.

The severity of this non-compliance is minimal risk and the scope is widespread. The home does not have a history of non-compliance in this subsection of the legislation. [s. 115.] (213)

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacist and the pharmacy service provider and a registered dietitian who was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The licensee failed to ensure that the annual evaluation of the medication management system included a review of the quarterly evaluations in the previous year as referred to in O. Reg 79/10 s.115 and identified changes to improve the system in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The licensee failed to ensure that the changes identified in the annual evaluation were implemented and that a written record was kept of the results of the annual evaluation and of any changes that were implemented.

The home provided documentation of four Medication Management System Program Evaluations completed:
1.Date: September (no year identified), Review completed by: a Resident Care Coordinator (RCC).
2.Date: November 26, 2014, Review completed by: an RCC and a Registered Nurse (RN).
3.Date: blank, Review of Service from: September 2014 to: September 22, 2015, Review completed by: an RCC, and three RNs.
4.Date: blank, Review of Service from: August 2015 To: August 2016. Review completed by: two RNs.
The Medical Director, Administrator, Director of Nursing, Pharmacist and Dietitian were not included in any of the annual evaluations provided by the home.

The home was not able to provide any documentation of any quarterly evaluation completed that included the identification or implementation of changes to improve the system in accordance with evidence-based practices.

The program goals identified in the evaluations were random and different every year including "to provide the appropriate medication that resident require", "to provide minimal medication to maintain health of residents", "to keep residents as comfortable as possible", "to inform residents/POA's of medications being used have input", "quality control by MD, pharmacy, staff", "least medication possible", "to maintain safe and appropriate medication administration, dosing and kind of medication".

There was no correlation between "summary of changes/improvements made of the past year with date of change" and the "areas for improvement identified" in the previous year's evaluation.

"Areas for improvement" were random, non-specific and vague, including "continue to assess over medication of elderly, discontinue meds not needed, locking cart", and "double checks".

"Summary of changes/improvements made over the past year with date of change" were random, non-specific and vague, including "storage for discontinued meds has been improved so that removing items is harder", "double checks on waste of narcotics", "have new med cart that is 'erogmatic' for staff", "education of shift count", "review of medication use". No dates were indicated.

In an interview with the Medical Director on December 7, 2016, the physician said they had not participated in any Medication Management System program evaluations.

In an interview with an Administrator, the Administrator said they had not participated in any Medication Management System program evaluations.

In an interview with the Director of Nursing (DON), the DON said they had not participated in any Medication Management System program evaluations.

In an interview with three current and former Consultant Pharmacists, the Pharmacists said they had not participated in any Medication Management System program evaluations.

The medication policies in the Medical Pharmacies Pharmacy Policy & Procedure Manual for LTC Homes were reviewed:
Policy 3-5 "The Medication Cart and Maintenance" was dated January 2014. Policy 3-6 "The Medication Pass" was dated January 2014.
Policy 5-4 "Drug Destruction and Disposal" was dated January 2014.
Policy 9-2 "Adverse Drug Reactions and Drug Allergies" wasdatedJanuary2014. Policy 3-2-2 "Packaging- Strip Pack System" wasdatedJanuary2014.
Policy 3-12 "How to Administer Insulin (Insulin Pen)" was dated January 2014.

In an interview with the Acting Administrator, the Acting Administrator said that the home used the pharmacy provider Medical Pharmacies' policies for medication policies in the home. The Acting Administrator was not aware of who was responsible for reviewing policies or when it was done.

In an interview with the DON, the DON said that the home used the pharmacy provider Medical Pharmacies' policies for medication policies in the home. The DON was not aware of who was responsible for reviewing policies or when it was done.

The licensee failed to ensure that an interdisciplinary team that included the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacist and the pharmacy service provider and a registered dietitian who was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. The annual evaluation of the medication management system did not include a review of quarterly evaluations in the previous year as quarterly evaluations were not

completed or documented.

The licensee failed to ensure that the changes identified or implemented were based on a proper or adequate annual evaluation of the medication management system in accordance with evidence- based or prevailing practices.

The severity of this non-compliance is minimal risk and the scope is widespread. The home does not have a history of non-compliance in this subsection of the legislation. [s. 116.] (213)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacist and the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meet annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. To ensure that the annual evaluation includes a review of the quarterly evaluations in the previous year and identified changes to improve the system in accordance with evidence-based practices and if there are none, with prevailing practices. To ensure that the changes identified in the annual evaluation are to be implemented and a written record kept of the results of the evaluation and any changes that were implemented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remained in the original labelled container or package provided by the pharmacy provider or the Government of Ontario until administered or destroyed.

Observations on November 3, 2016, on one identified unit in the medication cart:
•Bins for four different residents contained medications not in the original package from the pharmacy, no resident name, date, prescription number, etc.

Observations on November 4, 2016, on another identified unit in a medication room:
Medication cart #1:
•Bins for five different residents contained medications not in the original package from the pharmacy, no resident name, date, prescription number, etc.

Medication cart #2:
•Bins for two different residents contained medications not in the original package from the pharmacy, no resident name, date, prescription number, etc.

In an interview with a Consultant Pharmacist, the Pharmacist said that the expectation was that medications were to be kept in their original packaging with the original label from the pharmacy and the directions for use.

In an interview with the Director of Nursing (DON), the DON said that it was the expectation that drugs were kept in their original container. The DON said that the home was aware that this was an issue in the home and that they had been discussing possible solutions with pharmacy.

The licensee failed to ensure that drugs remained in the original labelled container or package provided by the pharmacy provider until administered or destroyed.

The severity of this non-compliance is minimal risk and the scope is widespread. The home does not have a history of non-compliance in this subsection of the legislation. [s. 126.] (213)

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 remain in the original labelled container or package provided by the pharmacy provider or the Government of Ontario until administered or destroyed, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

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

In an interview with the Director of Nursing (DON), the DON said that they had never done any audits of the daily count sheets of controlled substances and was not aware that that this was required.

The home was not able to produce any audits of daily count sheets of controlled substances.

The licensee failed to complete a monthly audit of the daily count sheets of controlled substances to determine if there were any discrepancies.

The severity of this non-compliance is minimal risk and the scope is widespread. The home does not have a history of non-compliance in this subsection of the legislation. [s. 130. 3.] (213)

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 a monthly audit is undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies, and that immediate action is taken if any discrepancies are discovered, to be implemented voluntarily.

WN #6: 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 following is additional evidence to support Compliance Order #002 identified in a concurrently completed critical incident inspection #2016_229213_0039 with a compliance date of May 26, 2017.

A) The licensee has failed to ensure that the Drug Destruction and Disposal policy was complied with.

O.Reg 79/10, s.136 (2) states: "The Drug Destruction and Disposal" policy must also provide for the following: 1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident until the destruction and disposal occurs".

The home's policy #5-4, "Drug Destruction and Disposal", dated January 2014 indicated: "2. The nurse who processes the medication "to be disposed of or discontinued" order is responsible for removing the medication(s) from the medication cart, medication room cupboards, [as needed] bin, refrigerator and treatment carts.
4.Medications for destruction are removed from all medication storage areas and retained in a secure area in the medication room, separate from medications for administration to a resident, until such time as they are transferred to the designated Stericycle box/container for destruction and disposal. A surplus medications log (Drug Destruction and Disposal Log for Non-Narcotic and Controlled Medications) may be used to track additions to the box as per specific home policy."

Observations on November 3, 2016 in one identified unit medication room:
•The fourth drawer of the medication cart contained a bin with a specimen collection bottle with multiple random pills and capsules in it, no label on the bottle and an open

medication strip package for a resident with a crushed yellow pill in it and strip pack not sealed or closed.

Observations on November 3, 2016 in another identified unit medication room:
•The fourth drawer of the medication cart contained a bin with a specimen collection bottle with multiple random pills and capsules in it with "D/C" written in black marker on the lid.

Observations on November 4, 2016 in another identified unit medication room:
•The fourth drawer of a medication cart contained a bin with a urine collection bottle with multiple random pills and capsules in it, with "refused/wasted" written on the bottle with black marker and an open medication strip package for a resident with crushed pills in it with the strip pack not sealed.

In an interview with a Consultant Pharmacist, the Pharmacist said the expectation of the home was that medications for destruction were to be put in the box designated for medication disposal on each unit, and not kept in the medication cart.

In an interview with the Director of Nursing (DON), the DON said that the pills should not have been kept in a specimen collection container in the medication cart.

The licensee failed to ensure that written policies and protocols for the medication management system to ensure the destruction and disposal of all disposal of all drugs used in the home, were implemented.

B) The licensee has failed to ensure that the Expiry and Dating of Medications policy was complied with.

O. Reg. 79/10 s. 136.(1)(a) states: "Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of, (a) all expired drugs".

The Medical Pharmacies policy #5-1 "Expiry and Dating of Medications" dated February 2017 states "examine the expiry date of all medications on a regular monthly basis" and "remove any expired medications and order replacement if necessary". The policy further states "treat expired prescription medications as medications for disposal".

Observations on November 3, 2016 in an identified unit in the medication room included:
•The cupboard containing government stock medications contained a bottle of an identified medication with an expiry date of October 2016.
A registered nursing staff confirmed that the medication had an expiry date of October 2016 and should not have been in the cupboard, they removed the medication from the cupboard.

Observations on November 3, 2016 on another identified unit in the medication room included:
•The 4th drawer contained a bin with government stock medications, including a bottle of an identified medication with an expiry date of September 2016.
•The cupboard containing government stock medications contained a bottle of an identified medication with an expiry date of October 2016.

Observations on November 4, 2016 in another identified unit in the medication room included:
•The bottom drawer of a medication cart contained a bottle of an identified medication with an expiry date of October 2016.
•The bin for a resident contained a bottle of identified medication with an expiry date of October 2016.

In an interview with the Director of Nursing (DON), the DON confirmed the expectation that expired medications should not have been stored in medication carts or cupboards. The DON said that the expectation was that the carts and cupboards were checked at least every two months and expired medications removed and destroyed.

In an interview with a registered staff member, the registered staff said that expired medications were to be removed from use and destroyed. The registered staff said that it was the responsibility of every registered staff to check for expiry dates of medications.

In an interview with a Consultant Pharmacist, the Pharmacist said that the pharmacy regularly audits for expired medications and the expectation was that the home was also to be auditing on a regular basis to ensure that there was no expired medications stored with medications for administration.

The severity of this non-compliance is minimal risk and the scope is widespread. The home does have a history of non-compliance in this subsection of the legislation. This was issued as a Voluntary Plan of Correction in May 2014, as a Written Notification in

October 2014, and August 2014, and as a Voluntary Plan of Correction in October 2016. This was also issued as Compliance Order #001 in a concurrently completed critical incident inspection #2016_229213_0039 with a compliance date of May 26, 2017. [s. 8. (1) (b)] (213)

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The following is additional evidence to support Compliance Order #003 identified in a concurrently completed critical incident inspection #2016_229213_0039 with a compliance date of May 26, 2017.

The Caressant Care Nursing & Retirement Home Ltd. Policy and Procedure, Schedule D titled Abuse & Neglect- Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff reviewed August 2016, stated all cases of suspected or actual abuse must be reported in written form to the Director of Nursing (DON)/Administrator and in the absence of management, to notify the charge nurse immediately who will contact manager on call.

A human resource file of a registered staff member was reviewed. It contained a written report by a Personal Support Worker (PSW) expressing concerns of suspected staff to resident abuse and neglect involving a staff member on multiple identified dates. The PSW documented the concerns in a letter to the Director of Nursing (DON). The DON initialed the letter as received five weeks after the initial concern was identified by the PSW.

In an interview, the PSW said that the complaint to the DON was a running tally of concerns that started on an identified date and were not immediately reported. The date the letter was received by the DON was over a month after the PSW's first concern of neglect identified in the letter.

The licensee failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with when a PSW did not immediately report all cases of suspected or actual abuse in writing to the Director of Nursing (DON)/Administrator. (137)

The severity of this non-compliance is actual harm/risk and the scope is isolated. The home does have a history of non-compliance in this subsection of the legislation. It was issued as a Voluntary Plan of Correction on July 26, 2017. This was also issued as a Voluntary Plan of Correction in a concurrently completed critical incident inspection #2016_303563_0042 on January 24, 2017, and as Compliance Order #002 in a currently completed critical incident inspection #2016_229213_0039 with a compliance date of May 26, 2017. [s. 20. (1)] (213)

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knew of, or that was reported was immediately investigated and that appropriate action was taken in response to every such incident.

The following is additional evidence to support Compliance Order #003 identified in a concurrently completed critical incident inspection #2016_303563_0042 with a compliance date of March 1, 2017.

"Verbal abuse" means, any form of verbal communication of a threatening or intimidating nature or any form of communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth that is made by anyone other than a resident.

The home submitted a Critical Incident (CI) System report to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, related to an alleged incident of resident to staff abuse involving the manner in which a resident spoke to a staff member that occurred on the date of the report.

The home's internal investigation records were reviewed. These records contained written complaints from two staff members to the Director of Nursing (DON) expressing concern over a suspected staff to resident abuse involving the same staff member and resident as in the CI report.

The home's internal investigation records documented limited management response to the alleged staff to resident verbal abuse.

In an interview with the DON, the DON acknowledged that they were aware of the two written staff complaints. When asked if the DON would consider that type of behaviour appropriate or acceptable, the DON said no, it's not acceptable. When asked if there was any action taken related to the inappropriate staff to resident communication, the DON said they did not see any and was unsure as to why.

The staff statements reported to the home can be considered verbal abuse. As the Director of Care was made aware of these statements by the two staff members, the home had reasonable grounds to suspect verbal abuse. The licensee failed to

immediately investigate the reported staff to resident verbal abuse of a resident or take appropriate actions.

The severity of this non-compliance is minimal risk, the scope is wide spread with one out of one resident affected. The home has a history of non-compliance in this subsection of the legislation; it was issued as a voluntary plan of correction on October 20, 2016. This was issued as Compliance Order #003 in a concurrently completed critical incident inspection #2016_303563_0042 with a compliance date of March 1, 2017. [s. 23. (1)] (213)

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect thatabuse of a resident by anyone, or incompetent or improper treatment pr care of a resident that resulted in harm or risk of harm to the resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

The following is additional evidence to support Compliance Order #002 identified in a

concurrently completed follow up inspection #2016_229213_0038 with a compliance date of January 27, 2017.

A) The home submitted a Critical Incident (CI) System report to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date, related to an alleged incident of resident to staff abuse, involving the manner in which a resident spoke to a registered staff member that occurred on the same date as the report.

The home's internal investigation records were reviewed. These records contained written complaints from two staff members to the Director of Nursing (DON) expressing concern over a suspected staff to resident abuse involving the same staff member and resident as in the CI report.

In an interview with the DON, the DON said that they were aware of the two written staff complaints alleging staff to resident verbal abuse. When asked if the DON would consider that type of behaviour appropriate or acceptable, the DON said no, it's not acceptable. When asked if there was any action taken related to the inappropriate staff to resident communication, the DON said they did not see any and was unsure as to why.

In reviewing the Ministry of Health and Long Term Care Critical Incident System, there were no other critical incidents reported related to this resident other than the report related to resident to staff abuse.

The statements reported to the home can be considered verbal abuse. As the Director of Care was made aware of these statements by the two staff members, the home had reasonable grounds to suspect verbal abuse. The home failed to immediately report the suspicion of verbal abuse of a resident to the Director, when it was reported to the home. (213)

B) Human resource records were reviewed. Email communication and investigation meeting documentation on an identified date, stated a resident exhibited responsive behaviours. There was no documented evidence that interventions, other than chemical restraints, were utilized, in an attempt to manage the behaviours.

The investigation notes and resident electronic records documented an incident where a staff member used chemical restraints with respect to the resident.

In an interview with the DON, the DON said the incidents occurred and that type of

behaviour was inappropriate and unacceptable for a staff member.

In reviewing the MOHLTC CI System, there were no CI reports related to that resident other than a report related to resident to resident abuse on the same date the responsive behaviours were exhibited.

The home's internal investigation records were reviewed and stated that follow up occurred related to a resident being given medication outside of the allowable time frame, was spoken to in an inappropriate manner that resulted in upsetting the resident and failed to document the interventions tried for this resident.

The home failed to immediately report an incident of improper treatment of resident to the Director when the resident received medications outside of the allowable time frames and was spoken to in an inappropriate manner that resulted in upsetting the resident. (137)

C) The home submitted a Critical Incident (CI) System report to the MOHLTC on an identified date,related to a fall that occurred on the date of the report where resident sustained injuries.

The home received a written complaint on an identified date from a staff member about improper or incompetent care of the resident’s injuries by another staff member.

The home's internal investigation records were reviewed and included documentation that follow up occurred related to not meeting the required needs of residents in a timely manner and not following policy and procedure after a fall.

In an interview with the DON, the DON said the incidents occurred as stated in the written complaint and that the treatment and care provided by the staff member of the resident’s injuries was improper.

In reviewing the Ministry of Health and Long Term Care Critical Incident System, there were no other critical incidents reported related to the resident receiving improper or incompetent treatment or care.

The home failed to immediately report an incident of improper or incompetent treatment or care that resulted in harm or risk of harm to a resident when the resident was provided improper or incompetent treatment. (137)

The severity of this non-compliance is minimal risk, the scope is isolated. The home has a history of non-compliance in this subsection of the legislation; a compliance order was issued on November 25, 2015, reissued on October 20, 2016 with a compliance date of October 31, 2016, and reissued in concurrently completed follow up inspection as Compliance Order #002 with a compliance date of January 27, 2017. [s. 24. (1)] (213)

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Findings/Faits saillants :

1. The licensee has failed to ensure that screening measures were conducted in accordance with the regulations, including criminal reference check conducted, before hiring staff.

A review of human resource files was conducted. The Inspector found two staff members were hired on identified dates and worked shifts. There was no criminal reference check or a police vulnerable sector screen found in the human resource files.

The Police Vulnerable Sector Check in one employee file was dated as completed by the police three days after the staff member's first shift worked.

In an interview, the Director of Nursing (DON) said that an audit had been done and it was pointed out that the criminal reference check or a police vulnerable sector screen, for one of staff, was missing. The staff had been asked to bring it in and was placed off work until it was received. A week later, the DON said that the Police Vulnerable Sector Check was received by the home, and provided a copy, it was dated as completed by the police 32 days after their first shift worked.

In interviews, the Acting Administrator, Administrator and the Director of Nursing said it was the home's expectation that employees were not to be hired or start performing their duties without a criminal reference check or a police vulnerable sector screen conducted within six months of being hired.

The licensee failed to ensure that screening measures including criminal reference checks, for two staff members were completed before they were hired and performed their duties.

The severity of this non-compliance is minimal risk and the scope is isolated. The home does not have a history of non-compliance in this subsection of the legislation. [s. 75.] (213)

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

The licensee has failed to ensure that, (a) the documented record was reviewed and analyzed for trends at least quarterly; (b) the results of the review and analysis were taken into account in determining what improvements are required in the home; and (c) a written record was kept of each review and of the improvements made in response.

In an interview with an Administrator, the Administrator said that they were unable to locate any documentation related to complaints for the years 2010 to 2014.

In an interview with an Administrator, the Administrator said they did not have a formal process for documenting complaints prior to 2015.

In interview with the Director of Nursing (DON), the DON said that they did not keep records of complaints prior to 2015.

The home was not able to produce any documentation related to any complaints or analysis of complaints for the years 2010 to 2014.

The scope of this non-compliance is minimal risk, and the scope is widespread. The home does have a history of non-compliance in this subsection of the legislation, it was issued as a compliance order during the Resident Quality Inspection (RQI) on October 19, 2015 and complied in the RQI on August 30, 2016. [s. 101.] (213)

WN #12: 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 in accordance with the directions for use specified by the prescriber.

There were 41 medication incidents documented in Risk Management in Point Click Care for the time period of August 7, 2016 to December 28, 2016. Of the 41 incidents, 37 out of 41 were medications not administered in accordance with directions for use by the prescriber:
•Five out of 41 were medications given to wrong resident
•Three out of 41 were medications given at the wrong time
•Six out of 41 were the wrong dose of medications was given
•22 out of 41 were medications not given at all
•One out of 41 was medication given with no prescription from the physician
All of these 41 medication incidents documented in Risk Management in Point Click Care were signed by the Director of Nursing.

In an interview with the Director of Nursing (DON), the DON said that all medication incidents were documented in Risk Management in Point Click Care.

In another interview with the DON, the DON said that they were aware of the medication incidents reported in Risk Management in Point Click Care. The DON stated that the reason for the incidents was that staff were not following the proper procedure for medication administration; that they were aware of the problem and they were following up with staff.

In an interview with the DON, the Acting Administrator and the two new Resident Care Coordinators, the DON acknowledged that numerous medication incidents had occurred, that they were concerning, and required action by the home.

In another interview with the DON, the DON said that they go in to Risk Management in Point Click Care regularly to check for new medication incidents submitted, reviews and

signs them. The DON said that their signature indicated that they were aware of the medication incident, and not necessarily that the follow up was completed.

The licensee failed to ensure that medications were administered in accordance with directions for use by the prescriber as 37 medication incidents were documented as medications not given, given at the wrong time, given to the wrong resident, given without a physician's order or not given at all over less than five month period of time. [s. 131. (2)] (213)

2.The following is further evidence to support Compliance Order #901 issued January 25, 2017 in this inspection, with a compliance date of January 27, 2017.

There is also further evidence to support Compliance Order #901 in a concurrently completed critical incident inspection #2016_229213_0039.

A) A human resource file for a registered staff member was reviewed. There were 13 medication related incidents committed by a registered staff member for an identified period of time, including:
•three medications given at the wrong time
•seven medications not administered
•one wrong medication given
•one missing controlled substance at shift count and possible double dose given
•one incident where a pharmacy incident was not communicated to oncoming shift which resulted in a resident missing four doses of prescribed medication by other registered staff.

In an interview with the Director of Nursing (DON), the DON said that they were aware of the above medication incidents committed by this registered staff and that the residents involved in these medications did not receive their medications as specified by the prescriber.

B) The electronic Medication Administration Record (MAR) for a resident for an identified month was reviewed. The Mar showed that four different registered staff administered morning and evening doses of an identified medication over the course of four consecutive identified dates.

A medication incident report was completed on an identified date by a registered staff member. The medication incident occurred on four identified dates, when one registered

staff put the wrong medication in the medication cart for a resident. Four different registered staff administered the wrong medication to a resident over the course of four consecutive identified dates.

The home's internal investigation records were reviewed. There was documentation of an interview and follow up with one registered staff where it was determined that one registered staff put the wrong medication in the medication cart for this resident.

In an interview with the DON, the DON said that they were aware of an initial incident on an identified date, and agreed that the resident received the wrong medication for four consecutive days administered by four different registered staff.

The home failed to ensure that medication was administered to a resident in accordance with the directions for use specified by the prescriber.

The severity of this non-compliance is minimal harm/risk or potential for actual harm/risk and the scope is widespread. The home does not have a history of non-compliance in this subsection of the legislation. Compliance Order #901 was issued January 25, 2017 in this inspection, with a compliance date of January 27, 2017. [s. 131. (2)] (213)

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

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 substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. In addition to the requirement under clause (1) (a), the licensee failed to ensure that, (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed; (b) corrective action was taken as necessary; and (c) a written record was kept of everything required under clauses (a) and (b).

A review of Risk Management in Point Click Care was completed. There were 41 medication incidents documented, 37 out of 41 were medications not administered in accordance with directions for use by the prescriber:
•Five out of 41 were medications given to wrong resident
•Three out of 41 were medications given at the wrong time
•Six out of 41 were the wrong dose of medications was given
•22 out of 41 were medications not given at all
•One out of 41 was medication given with no prescription from the physician
All of these 41 medication incidents documented in Risk Management in Point Click Care were signed by the Director of Nursing.

A medication incident was found reported in risk management where a resident did not receive one dose of medication. The Medication Administration record for that month indicated a "9" in the noon time slot for that date. The MAR legend described a "9" indicated "other/see nurse notes". A late entry in the progress notes for the resident stated medications were received late at 0800 hours and noon dose was not given. There was no indication of an assessment or tests in Point Click Care or the paper chart for the resident.

Staff interview with a registered staff member, they stated the expectation would have been to assess the resident when the dose of medication was given late and when the 1200 hours dose of medication was not given. After reviewing the physician’s orders for the resident, the registered staff agreed that the resident did not have a physician’s order for appropriate testing and should have.

In an interview with a Resident Care Coordinator (RCC), the RCC said that the expectation would have been to assess the resident when their morning dose of medication was given late and the noon dose was not given.

In an interview with a Consultant Pharmacist, the Pharmacist said that they and the pharmacy have not received all medication incidents that occurred in the home, only those involving pharmacy incidents and therefore, did not review every medication incident. The Pharmacist said they were unaware of the number of medication incidents committed in the home over a four month period.

In an interview with another Consultant Pharmacist, the Pharmacist said that they and the pharmacy received some but not all of the medication incidents that occurred in the

home. Only those involving pharmacy errors were received and therefore, did not review every medication errors. The pharmacist said they were unaware of the number of medication errors committed in the home over a four month period.

In an interview with the Medical Director (MD), the Physician said that they were not made aware of all medication incidents, only the incidents involving the patients under their care.

The home's Medication Management System Program Evaluations were reviewed from 2012 to 2016. The Medication Management System Program Evaluation completed August 2015 to August 2016 completed by two Registered Nurses indicated in "Areas for Improvement - to decrease number of med incidents - missed". "Date results taken to CQI committee September 8, 2016".

The home's Professional Advisory Team (PAT) meeting minutes were reviewed from November 2008 to November 2016. In an interview with the Acting Administrator, the Acting Administrator shared that the Professional Advisory Team meets quarterly and that the Medical Director, the Consultant Pharmacist, and the Director of Nursing attend these meetings. The minutes included a review of the number and type of medication incidents. No documentation was found related to actions for improvement in medication incidents in any of the PAT meeting minutes from November 2008 to November 2016.

The home's Quality Improvement /Risk Quarterly Reports from 2012 to 2016 were reviewed. No documentation was found related to actions for improvement in medication incidents in any of the Quality Improvement/Risk Quarterly Reports from 2012 to 2016.

The home's Continuous Quality Improvement (CQI) meeting minutes were reviewed for 2016. Meeting minutes were provided by the Acting Administrator for January, March, May, August and September, 2016. No documentation was found related to medication incidents or actions for improvement in medication incidents in any of the CQI meeting minutes in 2016.

In an interview with the Acting Administrator, the Acting Administrator said that medication incidents are reviewed quarterly during the Professional Advisory Committee meetings. The Acting Administrator said that medication incidents should also be reviewed in the Medication Management System Program Evaluation. The Acting Administrator also said that there is now a system for the pharmacy to be notified of all medication incidents as well as in Risk Management, but prior to December 2016,

pharmacy was not notified of all medication incidents.

The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented with a record of the immediate actions taken to assess and maintain the resident’s health; reported to the Medical Director and the pharmacy service provider. In addition, the licensee failed to ensure that corrective action was taken as necessary for every medication incident involving resident or for the analysis medication incidents that occurred in the home. [s. 135.] (213)

2.The following is further evidence to support Compliance Order #902 issued January 25, 2017 in this inspection, with a compliance date of April 28, 2017.

A) A medication incident report was completed on an identified date by a registered staff member.A resident had a physician's order for an identified medication to be administered. The medication incident occurred on four identified dates, when one registered staff put the wrong medication in the medication cart for this resident. Four different registered staff administered the wrong medication to a resident over the course of the four identified dates.

The electronic Medication Administration Record (MAR) for the resident for that time period was reviewed. The Mar showed that four different registered staff administered morning and evening doses of an identified medication over the course of four consecutive identified dates.

The home's internal investigation records were reviewed. There was documentation of an interview and follow up with one registered staff. There was no other documentation of interviews or follow up with the three other registered staff who administered the wrong medication to the resident.

The other three registered staff were interviewed by the Inspectors and said that they were unaware that they had made the medication error of giving the resident the wrong medication on the identified dates and had not spoken to anyone regarding the incident. All three registered staff confirmed their initials on the MAR as administering the documented dose of medication on the identified dates.

In an interview, the Acting Director of Nursing (DON), the Administrator and the two Resident Assessment Instrument Coordinators (RAI-C), they said that the expectation of the home was that registered staff complete a medication incident report in risk

management in Point Click Care when a medication incident or incident was discovered. Inspector #213 asked the Acting DON, the Administrator, and the two RAI-C for the policy related to medication incidents and Risk Management in Point Click Care. No one was able to produce a policy related to medication incidents or risk management.

In an interview with the DON, the DON said that they were aware of the initial incident that occurred when the first registered staff member put the wrong medication in the medication cart, but did not consider that the resident had received the wrong medication for four consecutive days or that three other registered staff members had made a medication incident of administering the wrong medication to the resident. The DON said that they did not speak with, interview or take any follow up actions with the three other registered staff members regarding the medication incident where the resident received the wrong medication.

The home failed to ensure that corrective action was taken as necessary for the medication incident involving resident.

A) The employee file for a registered staff member was reviewed. There were 13 medication related incidents committed by this registered staff during a specified period of time including:
•three medications given at the wrong time
•seven medications not administered
•one wrong medication given
•one missing controlled substance at shift count and possible double dose given
•one incident where a pharmacy incident was not communicated to oncoming shift which resulted in a resident missing four doses of prescribed medication by other registered staff.

The severity of this non-compliance is minimal harm/potential for harm and the scope is widespread. Compliance order #902 was issued on January 25, 2017 with a compliance date of April 28, 2017. Previous to Compliance Order #902, the home did not have a history of non-compliance in this subsection of the legislation. [s. 135.] (213)

Issued on this 17th day of August, 2017

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

Original report signed by the inspector.