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

London Service Area Office
130 Dufferin Avenue 4th floor
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130 avenue Dufferin 4ème étage
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 29, 2017	2017_605213_0008	002942-17, 003556-17, 004126-17, 004666-17, 007012-17	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 WOODSTOCK NURSING HOME
81 FYFE AVENUE WOODSTOCK ON N4S 8Y2

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

RHONDA KUKOLY (213)

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): May 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 2017.

This complaint inspection was completed related to:
Log #0047126-17, Infoline #IL-49481-LO, Complaint regarding concerns related to medication administration.
Log #003556-17, Critical Incident #2636-000013-17 regarding a medication incident.
Log #004666-17, Critical Incident #2636-000017-17 regarding alleged staff to resident abuse.
Log #07012-17, Critical Incident #2636-000024-17 regarding responsive behaviours and medications.
Log #002942-17, Critical Incident #2636-000009-17 regarding a medication incident.
Follow up to Immediate Order #901 issued January 25, 2017 with a compliance date of January 27, 2017 in Inspection #2016_229213_0035 regarding medication administration.

This inspection was completed concurrently while in the home completing follow up inspection #2017_605213_0007.

During the course of the inspection, the inspector(s) spoke with the Regional Manager, the Vice President of Operations for Caressant Care Nursing and Retirement Homes Limited, the Administrator, the Director of Care, a Resident Care Coordinator, a Pharmacist, Registered Nurses, Registered Practical Nurses, residents and family members.

The Inspector also made observations and reviewed health records, internal investigation records, complaint logs and documentation, meeting minutes, audits, education records, evaluations, policies and procedures and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Medication
Prevention of Abuse, Neglect and Retaliation

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

2 WN(s)
0 VPC(s)
1 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. 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.

A review of medication incidents documented in Risk Management in Point Click Care (PCC) was completed. There were 42 medication incidents documented for the time period of January 28, 2017 to May 1, 2017; a three month period. Two medication incidents related to equipment malfunction resulting in missed doses were reported to the Ministry of Health and Long Term Care in Critical Incident Reports, but were not documented in Point Click Care Risk Management. Of the 44 incidents, 35 out of 44 were medications not administered in accordance with directions for use by the prescriber:

- 1 out of 44 were medications given to wrong resident.
- 1 out of 44 were medications given at the wrong time.
- 6 out of 44 were the wrong dose of medication was given.
- 24 out of 44 were medications not given at all.
- 3 out of 44 were the wrong medication given.

A complaint was received by the Ministry of Health and Long Term Care from the family member of a resident regarding medication errors. Medication incidents were reviewed in Risk Management in PCC between a four month period of time. Four medication incidents were found that involved that resident including:

- One incident of the wrong dose was given.
- Two incidents of the dose was missed and not given.
- One incident of the medications were given at the wrong time.

During the inspection, progress notes in PCC stated that an identified resident received an identified medication at a specific time although the physician's order for that

medication directed the medication be given at a different time of the day when needed.

The Medication Administration Records (MARs) for a resident were reviewed for a four month period of time. Documentation in the MARs stated this resident received the identified medication at identified times that were not at the time specified on the physician's order, on twelve occasions during the four month period of time.

In an interview with the Administrator and the Regional Manager, they both said that the medication given at the identified time was a medication error as the medication was not given at the time directed in the physician's order. The Regional Manager said that there has not been a decrease in medication errors in the home with the main problem being that registered staff were not reading the MARs and giving medications as per the direction in the MARs.

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

The severity of this incident is minimal harm or potential for actual harm and the scope is widespread. The home has a history of non-compliance in this subsection of the legislation, it was issued as Compliance Order #901 on January 25, 2017 with a compliance date of January 27, 2017 in Inspection #2016_229213_0035. [s. 131. (2)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Findings/Faits saillants :

1. The following is further evidence to support Compliance Order #902 issued January 25, 2017 in inspection #2016_229213_0035 with a compliance date of April 28, 2017.

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 Medical Director 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).

O. Reg 35/10 defines a medication incident as: "a preventable event associated with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a prescription, and includes,
(a) an act of omission or commission, whether or not it results in harm, injury or death to a resident, or
(b) a near miss event where an incident does not reach a resident but had it done so, harm, injury or death could have resulted".

A review of Risk Management in Point Click Care (PCC) was completed for the time period of January 1, 2017 to April 30, 2017. There were 46 medication incidents documented in PCC, including:

- 6 in January.
- 13 in February.
- 13 in March.
- 14 in April.

A review of Critical Incident System (CIS) Reports reported to the Ministry of Health and Long Term Care (MOHLTC) was completed for the time period of January 1, 2017 to May 1, 2017. The following incidents related medications were reported:

- #2636_000009_17 related to a medication error for a resident where the resident did not receive medications as prescribed.
- #2636_000013_17 related to a medication error for another resident where the resident did not receive medications as prescribed.

In reviewing the medication incidents in Risk Management in PCC, the two incidents reported to the MOHLTC above, were not reported in Risk Management in PCC.

A review the home's documentation of analysis of medication incidents in the home for January to March, 2017 was completed April 1, 2017. The two incidents reported to the MOHLTC above, were not included in the analysis.

A review of Medical Pharmacies "C.C. Woodstock NH Medication Incidents" for January,

February and March, 2017 was completed. The reports included

- 6 in January.
- 11 in February.
- 5 in March.

In an interview with a Consultant Pharmacist, the Pharmacist said they were not aware of any other medication incidents other than the ones identified on the Medication Incidents MedeReport. The Medication Incidents MedeReport was a monthly report provided by the pharmacy provider that summarizes all of the medication incidents reported to the pharmacy, a description of the incident and a description of the causal factors if and when known.

In an interview with the Regional Manager (RM), the RMsaid that they were aware that all of the medication incidents/errors that occurred were not reported to the Pharmacy/Pharmacist, that the staff had reported them in Risk Management in PCC, but not in the online portal to the pharmacy. The RM said that they were not aware that two medication incidents that were reported to the MOHLTC, were not reported in PCC. The RM said that they used the medication incidents reported in PCC to complete the quarterly analysis of medication incidents in the home, and that the two medication incidents reported as CIS reports, numbers 2636_000009_17 and 2636_000013_17, were not included in the quarterly analysis. The RM said that the expectation was that registered staff document all medication incidents in both Risk Management in Point Click Care and via the online Medical Pharmacies portal, as this was how pharmacy is notified of incidents. The RM further said that there was still no policy to direct staff to document medication incidents in Risk Management in PCC and that the online pharmacy portal did not include documentation related to an assessment of the resident and actions taken to ensure the health of the resident.

The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to 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 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).

The severity of this incident is minimal harm or potential for actual harm and the scope is widespread. The home has a history of non-compliance in this subsection of the legislation, it was issued as Compliance Order #902 on January 25, 2017 with a

compliance date of April 28, 2017. [s. 135.]

Issued on this 19th day of July, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RHONDA KUKOLY (213)
Inspection No. / No de l'inspection :	2017_605213_0008
Log No. / Registre no:	002942-17, 003556-17, 004126-17, 004666-17, 007012-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 29, 2017
Licensee / Titulaire de permis :	CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED 264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	CARESSANT CARE WOODSTOCK NURSING HOME 81 FYFE AVENUE, WOODSTOCK, ON, N4S-8Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Angel Roth

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. Specifically, the licensee will:
1. Ensure that all registered staff have received training related to medication administration and the best practices, policies and procedures of the home and pharmacy provider related to medication administration.
2. Develop and implement a tracking system related to completion of medication administration training to ensure that all staff have been trained and when.
3. Develop and implement a plan for quality improvement related to medication administration and the reduction of medication incidents in the home including short and long term goals, strategies, responsible persons, indicators and target dates identified. The plan and outcomes must be evaluated quarterly to determine effectiveness and the need for changes to the plan, goals and strategies.
4. The quality improvement plan including dates, participants and discussion, as well as the quarterly evaluation and changes made, must be documented.

Grounds / Motifs :

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

A review of medication incidents documented in Risk Management in Point Click Care (PCC) was completed. There were 42 medication incidents documented for the time period of January 28, 2017 to May 1, 2017; a three month period. Two medication incidents related to equipment malfunction resulting in missed doses were reported to the Ministry of Health and Long Term Care in Critical Incident Reports, but were not documented in Point Click Care Risk

Management. Of the 44 incidents, 35 out of 44 were medications not administered in accordance with directions for use by the prescriber:

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

The severity of this incident is minimal harm or potential for actual harm and the

scope is widespread. The home has a history of non-compliance in this subsection of the legislation, it was issued as Compliance Order #901 on January 25, 2017 with a compliance date of January 27, 2017 in Inspection #2016_229213_0035. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 28, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 29th day of June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RHONDA KUKOLY

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