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
Aug 24, 2017	2017_605213_0015	016031-17, 016042-17	Follow up

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), ALI NASSER (523)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): July 31, August 1, 2, 3, 4, 2017

This follow up inspection was completed related to:
Log #016031-17, follow up to Compliance Order #002 related to the medication reconciliation policy, issued on May 24, 2017 in critical incident inspection #2016_229213_0039 with a compliance date of June 30, 2017.
Log #016042-17, follow up to Compliance Order #001 related to medication administration, issued on June 29, 2017 in complaint inspection #2017_605213_0008 with a compliance date of July 28, 2017.
A follow up to Immediate Order #902 related to medication incidents, issued on January 25, 2017 in critical incident inspection #2016_229213_0035 with a compliance date of April 28, 2017.

This inspection was completed concurrently while in the home completing:
Complaint Inspection #2017_605213_0016, Log #017641-17 related to staffing concerns.
Complaint Inspection #2017_605213_0017, Log #009047-17 related to care and medication management concerns.

Findings in Complaint Inspection #2017_605213_0017, related to O. Reg 79/10 s. 131(2) and s. 135 regarding medication administration and medication incidents have been issued in this inspection as further evidence to support Compliance Order #001 and #003.

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 Vice President of Quality Improvement, the Administrator, the Director of Care, two Resident Care Coordinators, Registered Nurses, Registered Practical Nurses, residents and family members.

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

The following Inspection Protocols were used during this inspection:

Medication

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

- **3 WN(s)**
- **0 VPC(s)**
- **3 CO(s)**
- **3 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. 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 adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident’s health; and 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, and the resident’s attending physician. In addition, all medication incidents were not documented, reviewed and analyzed; corrective action taken as necessary; and a written record kept of everything required.

This was follow-up to Immediate Order #902 related to medication incidents, issued on January 25, 2017 in critical incident inspection #2016_229213_0035 with a compliance date of April 28, 2017. The order stated:
"The licensee will ensure that for medication incidents and adverse drug reactions:
a) Every medication incident and adverse drug reaction will be documented with a record of the immediate and corrective actions taken to maintain the resident's health and to prevent re-occurrence.
b) Every medication incident and adverse drug reaction will be 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.
c) Medication incidents and adverse drug reactions will be reviewed and analyzed quarterly and annually in order to reduce and prevent medication incidents and adverse drug reactions; and a record kept of this.
d) Corrective action will be taken as necessary related to the results of the review and analysis of medication incidents and adverse drug reactions in order to reduce and prevent re-occurrence; and a record kept of this."

A review of Medication Incidents in Risk Management in Point Click Care was completed for a three month period. There were 19 medication incidents documented for this period of time, only 12 of which were actual errors involving a resident. Four incident reports

were reviewed from one month, and showed the following:

• A Medication Incident Report stated a medication patch was removed an hour after the patch was applied, when it should have been on for 24 hours, due to an order processing error. There was no documentation of the actions taken to maintain the resident's health. The Attending Physician and the Medical Director were not notified, and there was no record of review, analysis, review or actions taken related to this incident.
• A Medication Incident Report stated a resident received a medication for three extra days, it was ordered for seven days and they received it for ten days due to a receiving error. The resident/SDM was not notified, the Attending Physician and Medical Director were not notified. The online pharmacy report was completed (pharmacy notified) 16 days after the incident was discovered, and there was no record of review, analysis, review or actions taken related to this incident.
• A Medication Incident Report stated a resident was given a medication that had been discontinued six months earlier, but had not been destroyed and was still in the medication cart. The resident/SDM were not notified, the physician on call was notified. The Attending Physician and the Medical Director were not notified. The pharmacy was notified six days after occurrence. There was no record of review, analysis or actions taken related to this medication incident.
• A Medication Incident Report stated a medication strip was found in the medication cart the following shift having not been administered to the resident at the time directed. There was no record of action taken to assess and maintain the resident's health, the Medical Director was not notified, and there was no record of review, analysis or actions taken related to this medication incident.

In an interview with the Administrator and the Director of Nursing (DON), the DON said that when a medication incident was identified, the expectation was that staff complete a Medication Incident Report in Risk Management in Point Click Care and complete the online Medical Pharmacies Incident Report as well. The staff would assess and monitor the resident and ensure their safety, inform the resident/SDM, and the doctor. The staff would notify the DON, and if after business hours, they would notify the on call manager. The DON would also receive an emailed notification and copy of the Medical Pharmacies Incident Report once submitted. The DON and the Administrator said that the expectation was that the resident/SDM, the physician, and the DON were to be notified right away of a medication incident and the pharmacy would be notified via the Medical Pharmacies online incident report, completed right away.

A review of four medication incidents for one month with the Administrator and the DON

showed that:
• Two out of four incidents had no documentation of the immediate and corrective action taken to assess and maintain the resident's health.
• Two out of four incidents were not reported to resident/SDM, one was reported ten hours after discovery of incident.
• Two out of four incidents, the attending physician was not notified.
• Three out of four incidents, the medical director was not notified.
• Four out of four had no documentation that they were reviewed, analyzed, and corrective action was taken as necessary.
• Three out of four were not reported to pharmacy through the online form: One medication incident was completed eight days after occurrence, one was completed 16 days after occurrence, one was completed one day after occurrence.

A review of the "Woodstock Caressant Care Nursing - 2017 Medication Incidents", provided by the DON, showed that there was no documentation for those incidents in the Analysis/Trends/Corrective Action section.

In an interview, the Administrator and DON acknowledged that medication incidents were not being documented together with a record of the immediate actions taken to assess and maintain the resident's health, and were not reported to the resident, the resident's SDM, the Medical Director, the prescriber of the drug, the resident's attending physician and the pharmacy service provider. There was no written record demonstrating that all medication incidents and adverse drug reactions were reviewed and analyzed, and corrective action was taken as necessary. The Administrator and DON said that their expectation was that staff document immediate actions taken to assess the resident's health and ensure their safety, and that the resident/SDM, attending physician, medical director, DON, and pharmacy would be notified immediately of incidents. They said that all medication incidents would be reviewed and analyzed as they occurred, one by one, and the summary of the incidents would be discussed and analyzed during the quarterly Professional Advisory Committee meetings. The Administrator and DON acknowledged that the medication incidents reviewed demonstrated that they had not complied with Immediate Order #902, and did not meet their expectations of medication incident reporting or analysis.

The licensee failed to ensure that every medication incident involving a resident was documented with a record of the immediate actions taken to assess and maintain the resident's health; and reported to the resident/SDM, the Medical Director, the resident's attending physician; that all medication incidents and adverse drug reactions were

documented, reviewed and analyzed, corrective action taken as necessary, and a written record was kept, for the identified medication incidents.

The severity of this non-compliance is potential for actual harm and the scope was widespread. The home does have a history of non-compliance in this subsection of the legislation as it was issued as an Immediate Order on January 25, 2017 in a critical incident inspection. [s. 135.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with Compliance Order #002, pursuant to O.Reg 79/10, s. 8. (1)(b): 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 is complied with.

Compliance Order #002, issued on May 24, 2017, in Critical Incident Inspection #2017_229213_0039, with a compliance date of June 30, 2017, specifically stated:

"The licensee will ensure that the medication management system written policies and protocols are implemented. Specifically, the licensee will ensure:
a) Policy #4-3, Ordering Medications Using the Best Possible Medication History (BPMH) Reconciliation/Admission Form, is reviewed and revised as necessary.
b) All registered staff are educated regarding the Ordering Medications Using the Best Possible Medication History (BPMH) Reconciliation/ Admission Form policy and use of the form.
c) The home will develop and implement a process for tracking staff education including dates completed by staff, to ensure completion."

The Inspector requested the home's training records related to medication administration and tracking system for training. The Administrator provided a spreadsheet titled "Mandatory Education Tracking Sheet 2017 Registered Staff and Others", which included a column titled "BPMH". The tracking sheet did not include two registered staff members. The tracking sheet also did not include dates of training received for two other registered staff members.

In a meeting with the Administrator, the Director of Nursing (DON), and Resident Care Coordinators (RCC)s, one RCC wrote in a date for two registered staff stating that they had just received the training that day, at the time of the inspection. The RCC stated that these two registered staff did not receive the training related to the Best Possible Medication History Reconciliation/Admission form by the compliance date of June 30, 2017 and that one registered staff had not received the training to date. The RCC also provided the staff sign in sheet for the training as well as a three question quiz and the policy that was reviewed during the training. The policy was titled "Medication Reconciliation Onsite Pharmacist Version" #10-9. When asked, the RCC stated that this policy was the policy for the pharmacist to follow related to medication reconciliation and was not the policy directing the registered nursing staff related to medication reconciliation. The RCC said that they did review completion of the Best Possible Medication History Reconciliation/Admission form and the process for the registered staff to follow.

Four days later, the Administrator provided another spreadsheet titled "Mandatory Education Tracking Sheet 2017 Registered Staff and Others", which included the names of the two missing registered staff members indicating that one of the registered staff had received the BPMH in-service before the compliance date. There was no date indicated for the other registered staff member.

The licensee failed to comply with Compliance Order #002 issued on May 24, 2017 with a compliance date of June 30, 2017 when three registered staff members did not receive the training related to the licensee's policy entitled Best Possible Medication History Reconciliation/Admission form or when the tracking system related to completion of Best Possible Medication History Reconciliation training to ensure that all staff had been trained and when, and did not include the names of all registered staff.

The severity of this non-compliance is potential for actual harm and the scope is widespread. The home does have a history of non-compliance in this subsection of the legislation as it was issued as Compliance Order #002 on May 24, 2017 in Critical Incident Inspection #2016_229213_0039, with a compliance date of June 30, 2017 when it was followed up in a complaint inspection. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 no drug was used by or administered to a resident in the home unless the drug was prescribed for the resident.

A review of medication incident reports in Risk Management in Point Click Care was completed and showed a medication error stated a resident was given a medication that had been discontinued six months earlier, but had not been destroyed and was still in the medication cart.

A registered staff member said in an interview that they administered the medication from the medication cart but did not check the eMAR before giving the medication to the resident. The medication that was given was not prescribed for the resident at that time. The registered staff member said that the process for medication administration was for the nurse to check the eMAR before administering any medication and that they did not check the eMAR before administering the medication.

Medical Pharmacies policy #3-6 "The Medication Pass", dated February 2017, procedure #3 stated "find MAR for the resident and identify medication for the pass time". Procedure #4 stated "locate medications for the resident and check each medication label against MAR or eMAR to ensure accuracy".

In a meeting, the Director of Nursing (DON) and the Administrator said that a registered staff member gave medication without checking the eMAR and that was not the expectation, the expectation was for nurses to check the eMAR and ensure the right medication, dosage and time for the specific resident before administering any medication. The Administrator acknowledged that the medication that was given to the resident was not prescribed by the physician.

The licensee failed to ensure that no drug was administered to a resident in the home unless the drug was prescribed for the resident when resident received a medication without a physician's order. [s. 131. (1)]

2. 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 Incident Reports in Risk Management in Point Click Care was completed and included:
- A Medication Incident Report stated a medication patch was removed an hour after the patch was applied, when it should have been on for 24 hours, due to an order processing error.
- A Medication Incident Report stated a resident received a medication for three extra days, it was ordered for seven days and they received it for ten days due to a receiving

error.
• A Medication Incident Report stated that a nurse found the strip package of the previous shift medications were still in the resident's compartment in the medication cart, they were signed for as given, but they were not given.

In an interview, the Administrator and the Director of Nursing acknowledged that the medications noted above were not given as prescribed. They said that the expectation was for nurses to review physician orders, ensure they were transcribed to eMAR, and then administered to residents as per the eMAR.

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

3. The licensee has failed to comply with compliance order #001, pursuant to 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.

Compliance order #001, issued on June 29, 2017, in Critical Incident Inspection #2017_605213_0008, with a compliance date of July 28, 2017, specifically stated:
"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."

The Inspector requested the home's training records related to medication administration and the tracking system for training. The Administrator provided a spreadsheet titled "Mandatory Education Tracking Sheet 2017 Registered Staff and Others", which included a column titled "Wound Care, Abuse & Neglect, Mandatory Reporting, Med Admin In-

service". The tracking sheet did not include two current registered staff members. Four days later, the Administrator provided another spreadsheet titled "Mandatory Education Tracking Sheet 2017 Registered Staff and Others", which included the two registered staff, indicating that they received the Med Admin in-service before the compliance date.

The Inspector requested the Quality Improvement Plan related to the reduction of medication incidents. The Administrator provided a written document titled "Plan of Corrective Action, complaint inspection, date of review May 1-5 & 5-8, 2017, Order #001". The Plan of Corrective Action included ten strategies including: education and in-services, audits, staff discipline, medication error analysis completed monthly by DON, double check and signing of insulin required for all insulin given. The plan did not include any goals, objectives, indicators or target dates. In an interview with the Administrator, the Administrator acknowledged that the Quality Improvement Plan did not include short or long term goals, indicators, or target dates as required in the compliance order.

The Administrator also provided the "2017 Quality Improvement Quarterly Report". The Administrator stated that the Quality Improvement Report is a running report that is updated quarterly and it included the first and second quarters for 2017. There were no performance indicators, goals, indicators or strategies related to medication administration or the reduction of medication incidents noted in the report. The Administrator said that the reduction of medication incidents was not included in the 2017 Quality Improvement Quarterly Report.

The Administrator also provided the 2017 "Medication Management System Program Evaluation". The "Program Goals" stated "to provide safe and effective medication delivery to the residents of CCNH". The "Areas for Improvement" stated "improved completion of best possible medication reconciliation. Need to improve number of med errors and online reporting of medication incidents". The evaluation did not include short and long term goals, strategies, responsible persons, target dates or indicators. The Administrator said that the Medication Management System Program Evaluation was not a quality improvement plan and did not include the required items to support the compliance order.

The licensee failed to comply with Compliance Order #001 issued on June 29, 2017 with a compliance date of July 28, 2017 when they did not develop and implement a plan for quality improvement related to medication administration and the reduction of medication incidents in the home which was to include short and long term goals, strategies, responsible persons, indicators and target dates identified. In addition, the tracking

system related to completion of medication administration training to ensure that all staff have been trained and when, did not include the names of all registered staff.

The severity of this non-compliance is potential for actual harm and the scope is widespread. The home does have a history of non-compliance in this subsection of the legislation as it was issued as Compliance Immediate Order #901 on January 25, 2017, with a compliance date of January 27, 2017 in a Critical Incident inspection #2016_229213_0035, and it was re-issued as Compliance Order #001 on June 29, 2017, with a compliance date of July 28, 2017 when it was followed up in Complaint Inspection #2017_605213_0008. [s. 131. (2)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

Issued on this 25th day of August, 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), ALI NASSER (523)
Inspection No. / No de l'inspection :	2017_605213_0015
Log No. / No de registre :	016031-17, 016042-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Aug 24, 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:

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. 135. Medication incidents and adverse drug reactions

Order / Ordre :

The licensee will ensure that for medication incidents and adverse drug reactions:
a) Every medication incident and adverse drug reaction will be documented with a record of the immediate and corrective actions taken to maintain the resident's health.
b) Every medication incident and adverse drug reaction will be 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.
c) All medication incidents and adverse drug reactions are documented, reviewed and analyzed; corrective action will be taken as necessary and a written record kept of this.
d) Medication incidents and adverse drug reactions will be reviewed and analyzed quarterly in order to reduce and prevent medication incidents and adverse drug reactions; and a record kept of this.
e) The plan for quality improvement related to medication administration and the reduction of medication incidents in the home will include how and when the home will ensure that all of the above will be completed and by whom.

Grounds / Motifs :

1. The licensee has failed to ensure that every medication incident involving a resident and adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and 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, and the resident's attending physician. In addition, all medication incidents were not documented, reviewed and analyzed; corrective action taken as necessary; and a written record kept of everything required.

This was follow-up to Immediate Order #902 related to medication incidents, issued on January 25, 2017 in critical incident inspection #2016_229213_0035 with a compliance date of April 28, 2017. The order stated:
"The licensee will ensure that for medication incidents and adverse drug reactions:
a) Every medication incident and adverse drug reaction will be documented with a record of the immediate and corrective actions taken to maintain the resident's health and to prevent re-occurrence.
b) Every medication incident and adverse drug reaction will be 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.
c) Medication incidents and adverse drug reactions will be reviewed and analyzed quarterly and annually in order to reduce and prevent medication incidents and adverse drug reactions; and a record kept of this.
d) Corrective action will be taken as necessary related to the results of the review and analysis of medication incidents and adverse drug reactions in order to reduce and prevent re-occurrence; and a record kept of this."

A review of Medication Incidents in Risk Management in Point Click Care was completed for a three month period. There were 19 medication incidents documented for this period of time, only 12 of which were actual errors involving a resident. Four incident reports were reviewed from one month, and showed the following:

• A Medication Incident Report stated a medication patch was removed an hour after the patch was applied, when it should have been on for 24 hours, due to an order processing error. There was no documentation of the actions taken to maintain the resident's health. The Attending Physician and the Medical Director were not notified, and there was no record of review, analysis, review or actions taken related to this incident.
• A Medication Incident Report stated a resident received a medication for three extra days, it was ordered for seven days and they received it for ten days due to a receiving error. The resident/SDM was not notified, the Attending Physician and Medical Director were not notified. The online pharmacy report was completed (pharmacy notified) 16 days after the incident was discovered, and there was no record of review, analysis, review or actions taken related to this

incident.
• A Medication Incident Report stated a resident was given a medication that had been discontinued six months earlier, but had not been destroyed and was still in the medication cart. The resident/SDM were not notified, the physician on call was notified. The Attending Physician and the Medical Director were not notified. The pharmacy was notified six days after occurrence. There was no record of review, analysis or actions taken related to this medication incident.
• A Medication Incident Report stated a medication strip was found in the medication cart the following shift having not been administered to the resident at the time directed. There was no record of action taken to assess and maintain the resident's health, the Medical Director was not notified, and there was no record of review, analysis or actions taken related to this medication incident.

In an interview with the Administrator and the Director of Nursing (DON), the DON said that when a medication incident was identified, the expectation was that staff complete a Medication Incident Report in Risk Management in Point Click Care and complete the online Medical Pharmacies Incident Report as well. The staff would assess and monitor the resident and ensure their safety, inform the resident/SDM, and the doctor. The staff would notify the DON, and if after business hours, they would notify the on call manager. The DON would also receive an emailed notification and copy of the Medical Pharmacies Incident Report once submitted. The DON and the Administrator said that the expectation was that the resident/SDM, the physician, and the DON were to be notified right away of a medication incident and the pharmacy would be notified via the Medical Pharmacies online incident report, completed right away.

A review of four medication incidents for one month with the Administrator and the DON showed that:
• Two out of four incidents had no documentation of the immediate and corrective action taken to assess and maintain the resident's health.
• Two out of four incidents were not reported to resident/SDM, one was reported ten hours after discovery of incident.
• Two out of four incidents, the attending physician was not notified.
• Three out of four incidents, the medical director was not notified.
• Four out of four had no documentation that they were reviewed, analyzed, and corrective action was taken as necessary.
• Three out of four were not reported to pharmacy through the online form: One medication incident was completed eight days after occurrence, one was completed 16 days after occurrence, one was completed one day after

occurrence.

A review of the "Woodstock Caressant Care Nursing - 2017 Medication Incidents", provided by the DON, showed that there was no documentation for those incidents in the Analysis/Trends/Corrective Action section.

In an interview, the Administrator and DON acknowledged that medication incidents were not being documented together with a record of the immediate actions taken to assess and maintain the resident's health, and were not reported to the resident, the resident's SDM, the Medical Director, the prescriber of the drug, the resident's attending physician and the pharmacy service provider. There was no written record demonstrating that all medication incidents and adverse drug reactions were reviewed and analyzed, and corrective action was taken as necessary. The Administrator and DON said that their expectation was that staff document immediate actions taken to assess the resident's health and ensure their safety, and that the resident/SDM, attending physician, medical director, DON, and pharmacy would be notified immediately of incidents. They said that all medication incidents would be reviewed and analyzed as they occurred, one by one, and the summary of the incidents would be discussed and analyzed during the quarterly Professional Advisory Committee meetings. The Administrator and DON acknowledged that the medication incidents reviewed demonstrated that they had not complied with Immediate Order #902, and did not meet their expectations of medication incident reporting or analysis.

The licensee failed to ensure that every medication incident involving a resident was documented with a record of the immediate actions taken to assess and maintain the resident's health; and reported to the resident/SDM, the Medical Director, the resident's attending physician; that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, corrective action taken as necessary, and a written record was kept, for the identified medication incidents.

The severity of this non-compliance is potential for actual harm and the scope was widespread. The home does have a history of non-compliance in this subsection of the legislation as it was issued as an Immediate Order on January 25, 2017 in a critical incident inspection. (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 08, 2017

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_229213_0039, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee will ensure that the medication management system written policies and protocols are implemented. Specifically, the licensee will:
a) Ensure all registered staff have received training on the licensee's policy "Medication Reconciliation" policy and use of associated forms.
b) Develop and implement a process for tracking staff training including the dates when training was completed by staff, to ensure training is completed by all registered staff, and documented.

Grounds / Motifs :

1. The licensee has failed to comply with Compliance Order #002, pursuant to O.Reg 79/10, s. 8. (1)(b): 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 is complied with.

Compliance Order #002, issued on May 24, 2017, in Critical Incident Inspection #2017_229213_0039, with a compliance date of June 30, 2017, specifically stated:
"The licensee will ensure that the medication management system written policies and protocols are implemented. Specifically, the licensee will ensure:
a) Policy #4-3, Ordering Medications Using the Best Possible Medication History

(BPMH) Reconciliation/Admission Form, is reviewed and revised as necessary.
b) All registered staff are educated regarding the Ordering Medications Using the Best Possible Medication History (BPMH) Reconciliation/ Admission Form policy and use of the form.
c) The home will develop and implement a process for tracking staff education including dates completed by staff, to ensure completion."

The Inspector requested the home's training records related to medication administration and tracking system for training. The Administrator provided a spreadsheet titled "Mandatory Education Tracking Sheet 2017 Registered Staff and Others", which included a column titled "BPMH". The tracking sheet did not include two registered staff members. The tracking sheet also did not include dates of training received for two other registered staff members.

In a meeting with the Administrator, the Director of Nursing (DON), and Resident Care Coordinators (RCC)s, one RCC wrote in a date for two registered staff stating that they had just received the training that day, at the time of the inspection. The RCC stated that these two registered staff did not receive the training related to the Best Possible Medication History Reconciliation/Admission form by the compliance date of June 30, 2017 and that one registered staff had not received the training to date. The RCC also provided the staff sign in sheet for the training as well as a three question quiz and the policy that was reviewed during the training. The policy was titled "Medication Reconciliation Onsite Pharmacist Version" #10-9. When asked, the RCC stated that this policy was the policy for the pharmacist to follow related to medication reconciliation and was not the policy directing the registered nursing staff related to medication reconciliation. The RCC said that they did review completion of the Best Possible Medication History Reconciliation/Admission form and the process for the registered staff to follow.

Four days later, the Administrator provided another spreadsheet titled "Mandatory Education Tracking Sheet 2017 Registered Staff and Others", which included the names of the two missing registered staff members indicating that one of the registered staff had received the BPMH in-service before the compliance date. There was no date indicated for the other registered staff member.

The licensee failed to comply with Compliance Order #002 issued on May 24, 2017 with a compliance date of June 30, 2017 when three registered staff

members did not receive the training related to the licensee's policy entitled Best Possible Medication History Reconciliation/Admission form or when the tracking system related to completion of Best Possible Medication History Reconciliation training to ensure that all staff had been trained and when, and did not include the names of all registered staff.

The severity of this non-compliance is potential for actual harm and the scope is widespread. The home does have a history of non-compliance in this subsection of the legislation as it was issued as Compliance Order #002 on May 24, 2017 in Critical Incident Inspection #2016_229213_0039, with a compliance date of June 30, 2017 when it was followed up in a complaint inspection. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 08, 2017

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2017_605213_0008, CO #001;

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 must also include how the plan and outcomes will be evaluated quarterly (with the evaluation documented) to determine effectiveness and the need for changes to the plan, goals and strategies.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #001, pursuant to 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.

Compliance order #001, issued on June 29, 2017, in Critical Incident Inspection #2017_605213_0008, with a compliance date of July 28, 2017, specifically stated:
"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."

The Inspector requested the home's training records related to medication administration and the tracking system for training. The Administrator provided a spreadsheet titled "Mandatory Education Tracking Sheet 2017 Registered Staff and Others", which included a column titled "Wound Care, Abuse & Neglect, Mandatory Reporting, Med Admin In-service". The tracking sheet did not include two current registered staff members. Four days later, the Administrator provided another spreadsheet titled "Mandatory Education Tracking Sheet 2017 Registered Staff and Others", which included the two registered staff, indicating that they received the Med Admin in-service before the compliance date.

The Inspector requested the Quality Improvement Plan related to the reduction of medication incidents. The Administrator provided a written document titled "Plan of Corrective Action, complaint inspection, date of review May 1-5 & 5-8, 2017, Order #001". The Plan of Corrective Action included ten strategies including: education and in-services, audits, staff discipline, medication error analysis completed monthly by DON, double check and signing of insulin required for all insulin given. The plan did not include any goals, objectives, indicators or target dates. In an interview with the Administrator, the Administrator acknowledged that the Quality Improvement Plan did not include short or long term goals, indicators, or target dates as required in the compliance order.

The Administrator also provided the "2017 Quality Improvement Quarterly Report". The Administrator stated that the Quality Improvement Report is a

running report that is updated quarterly and it included the first and second quarters for 2017. There were no performance indicators, goals, indicators or strategies related to medication administration or the reduction of medication incidents noted in the report. The Administrator said that the reduction of medication incidents was not included in the 2017 Quality Improvement Quarterly Report.

The Administrator also provided the 2017 "Medication Management System Program Evaluation". The "Program Goals" stated "to provide safe and effective medication delivery to the residents of CCNH". The "Areas for Improvement" stated "improved completion of best possible medication reconciliation. Need to improve number of med errors and online reporting of medication incidents". The evaluation did not include short and long term goals, strategies, responsible persons, target dates or indicators. The Administrator said that the Medication Management System Program Evaluation was not a quality improvement plan and did not include the required items to support the compliance order.

The licensee failed to comply with Compliance Order #001 issued on June 29, 2017 with a compliance date of July 28, 2017 when they did not develop and implement a plan for quality improvement related to medication administration and the reduction of medication incidents in the home which was to include short and long term goals, strategies, responsible persons, indicators and target dates identified. In addition, the tracking system related to completion of medication administration training to ensure that all staff have been trained and when, did not include the names of all registered staff. (213)

2. 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 Incident Reports in Risk Management in Point Click Care was completed and included:
- A Medication Incident Report stated a medication patch was removed an hour after the patch was applied, when it should have been on for 24 hours, due to an order processing error.
- A Medication Incident Report stated a resident received a medication for three extra days, it was ordered for seven days and they received it for ten days due to a receiving error.
- A Medication Incident Report stated that a nurse found the strip package of the previous shift medications were still in the resident's compartment in the

medication cart, they were signed for as given, but they were not given.

In an interview, the Administrator and the Director of Nursing acknowledged that the medications noted above were not given as prescribed. They said that the expectation was for nurses to review physician orders, ensure they were transcribed to eMAR, and then administered to residents as per the eMAR.

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 non-compliance is potential for actual harm and the scope is widespread. The home does have a history of non-compliance in this subsection of the legislation as it was issued as Compliance Immediate Order #901 on January 25, 2017, with a compliance date of January 27, 2017 in a Critical Incident inspection #2016_229213_0035, and it was re-issued as Compliance Order #001 on June 29, 2017, with a compliance date of July 28, 2017 when it was followed up in Complaint Inspection #2017_605213_0008. (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 08, 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 24th day of August, 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