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 :	2016_229213_0035
Log No. / Registre no :	029609-16, 031470-16
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 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 :	Gay Goetz

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 : 902

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 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.

Grounds / Motifs :

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 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).

A review of Risk Management in Point Click Care was completed.There were 41 medication incidents documented, 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 the prescribed medications given to wrong resident.
- Three out of 41 were the prescribed medications given at the wrong time.
- Six out of 41 were the wrong dose of the prescribed medications was given.
- 22 out of 41 were the prescribed 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) A medication error was found reported in Risk Management where a resident did not receive one dose of medication. The Medication Administration (MAR) record indicated a "9" in the time slot for the missed dose. The MAR legend indicated a "9" indicates "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 the Registered Nurse (RN), the RN stated the expectation would have been to assess the resident when the dose of medication was given late and when the resident's 1200 hour dose of medication was not given. After reviewing the physician's orders for the resident, the RN agreed that the resident did not have a physician's order for appropriate testing and should have.

In an interview with the Resident Care Coordinator (RCC), the RCC said that the expectation would have been to assess the resident when the 0800 hour dose of medication was given late and when the1200 hour dose was not given.

b) Two medication incidents were documented in Risk Management in Point Click Care, whereby controlled substances were missing.
• There was 26 tablets at 0700 hours for the resident and the resident received one tablet. At the end of the shift, the count of the controlled substance was 24 tablets. Staff were "unable to locate where the missing tablet went and adjusted the count to 24, after the entire cart was checked".
• The narcotic count at 1500 hours for the resident indicated there were seven tablets at 1900 hours, there were five tablets remaining. The resident received one tablet at 1545 hours. "Staff were unable to determine when the miscount occurred".

In phone and email interviews with the DON, the DON said that she interviewed the two registered staff who reported the controlled substances missing. She said she had no documentation of the follow up or interviews with these registered staff regarding the missing controlled substance. She also said that she did not interview any of the other registered staff who participated in the controlled substances count at the beginning or end of the identified shifts.

In an interview with the Director of Nursing, by Inspectors #137 and #213, the DON acknowledged that she was aware of the medication incidents reported in

Risk Management in Point Click Care. She shared that the reason for the errors 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 (RCC) by Inspector #213, the DON acknowledged that numerous medication incidents had occurred, that they were concerning and required action by the home.

In an interview with the DON by Inspector #213, the DON said that they go in to Risk Management in Point Click Care regularly to check for new medication incidents submitted and reviews them and signs them. DON said that by adding their signature it indicated that they were aware of the medication incident and not necessarily that they had completed the follow up.

In an interview with the current Consultant Pharmacist, who had been providing services to the home, said that she and the pharmacy had not received all medication incidents that occurred in the home. Only those involving pharmacy errors were received and therefore, did not review every medication error. The consultant pharmacist said they were unaware of the number of medication errors committed in the home over a four month period.

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

The home's Medication Management System Program Evaluations were reviewed for 2015 and 2016. The Medication Management System Program Evaluation dated August 2015 to August 2016 completed by the Registered Nurse and Registered Nurse indicated in "Areas for Improvement - to decrease number of med errors - missed". "Date results taken to Continuous Quality Improvement (CQI) committee September 2016".

The home's Professional Advisory Team (PAT) meeting minutes were reviewed from May 2015 to November 2016. In an interview with the Acting Administrator, the Acting Administrator shared that the Professional Advisory Team met quarterly and that the Medical Director, the Consultant Pharmacist, and the Director of Nursing attended 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 errors in any of the PAT meeting minutes in 2015 or 2016.

The home's Quality Improvement /Risk Quarterly Reports for 2015 and 2016 were reviewed. No documentation was found related to actions for improvement in medication errors in any of the Quality Improvement/Risk Quarterly Reports in 2015 or 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 errors in any of the CQI meeting minutes in 2016.

In an interview the Acting Administrator said that medication incidents were reviewed quarterly during the Professional Advisory Team meetings and that medication incidents should also be reviewed in the Medication Management System Program Evaluation. The Acting Administrator also said that there was 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 home 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 home failed to ensure that corrective action was taken as necessary for every medication incident involving a resident or for the analysis of medication errors that occurred in the home.

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.
(213)

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