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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée***


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

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

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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 1, 2019 | 2019_591623_0001 | 028719-17, 003554-18, 006913-18, 006979-18, 008302-18, 016595-18, 017912-18, 025009-18, 025033-18, 025321-18, 025338-18, 031616-18, 000537-19 | Critical Incident System |

**Licensee/Titulaire de permis**

CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

**Long-Term Care Home/Foyer de soins de longue durée**

Hope Street Terrace
20 Hope Street South PORT HOPE ON L1A 2M8

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

SARAH GILLIS (623), KARYN WOOD (601), PATRICIA MATA (571)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): January 24, 25, 28, 30, 31,**

**February 1, 4, 5, 6, 8, 11, 2019**

**During the course of the inspection, the following logs were inspected concurrently:**
**Log #028719-17 for Critical Incident Report related to an outbreak in the home**
**Log #003554-18 for Critical Incident Report related to an allegation of neglect**
**Log #006913-18 for Critical Incident Report related to an allegation of neglect**
**Log #006979-18 for Critical Incident Report related to an allegation of abuse**
**Log #008302-18 for Critical Incident Report related to an outbreak in the home**
**Log #016595-18 for Critical Incident Report related to a fall resulting in an injury**
**Log #017912-18 for Critical Incident Report related to an allegation of neglect**
**Log #025009-18 for Critical Incident Report related to improper care resulting in injury**
**Log #025033-18 for Critical Incident Report related to alleged resident to resident abuse**
**Log #025321-18 for Critical Incident Report related to allegation of staff to resident abuse**
**Log #025338-18 for Critical Incident Report related to alleged resident to resident abuse**
**Log #031616-18 for Critical Incident Report related to a fall resulting in an injury**
**Log #000537-19 for Critical Incident Report related to an outbreak in the home**

**Critical Incident Report (CIR) Inspection #2019_591623_0001 and Complaint Inspection #2019_643111_0002 were completed concurrently. Non-compliance was identified for complaint log #012875-18 and a similar non-compliance was identified in CIR report #2019_591623_0001. The non-compliance that was identified in complaint log #012875-18 will be issued in CIR report #2019_591623_0001.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Registered Nurse(s) (RN), Registered Practical Nurse(s) (RPN), Personal Support Worker(s) (PSW), Restorative Care Aide, the RAI Coordinator, Behavioural Support staff (BSO), Physiotherapy Assistant (PTA), Physiotherapist (PT), the Scheduling Clerk, residents and families.**

**In addition, the inspectors reviewed clinical medical records, the licensee's internal investigations and related policies.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Infection Prevention and Control**
**Medication**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

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

- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the care set out in resident plan of care was provided to the resident as specified in the plan, related to transfers for resident #003.

Related to log #025009-18 for Critical Incident Report (CIR):

On a specified date, RPN #116 contacted the Ministry of Health and Long-Term Care Information Line upon becoming aware of an incident involving resident #003 being transferred by PSW #114.

Inspector #601 reviewed the specified Critical Incident Report (CIR), that was submitted to the Director. The CIR indicated that on a specific date and time, resident #003 asked PSW #114 to transfer them into bed. PSW #114 was aware that this resident required specified assistance for transfers. PSW #114 felt they could safely transfer the resident on their own. According to the CIR, PSW #114 put one arm under each of resident's arms, chest to chest, and pivoted them into bed. Once PSW #114 moved resident's arm on their stomach, the resident reported pain immediately in a specified area. At this time, PSW #114 reported to RPN #113 that resident #003 had discomfort after being transferred to bed. RPN #113 assessed resident #003's pain following the transfer and the resident received pain medication. Three days later, resident #003 received an X-ray in the Emergency Department and returned back to the Long-Term Care Home (LTCH) with a diagnosis of a specified injury.

On a specific date and time, Inspector #601 observed resident #003 sitting in their mobility device next to the bed and there was a transfer device located under the resident's bed. A bulletin board was also observed next to the resident's bed and there was a transfer logo indicating the resident was currently a specified transfer, with instruction to use a specified transfer device.

During an interview on a specific date and time resident #003 reported to Inspector #601 that they had specified limitations. Resident #003 further reported that the specified injury occurred during a transfer. Resident #003 indicated that the staff know the residents preference for rest periods and they were always working short. The resident indicated that the injury was both of their faults and that the PSW was having troubles finding someone to assist with the transfer. The resident indicated that they should have told PSW #114 that they could wait until the other nurse came to assist with the transfer. The resident indicated that they both knew that someone was required on both sides of them for transfers. The resident reported that currently two people are required for transfers and that staff are now being very careful. The resident also reported that the Physiotherapist had implemented a specific transfer device following the incident and that this was helpful.

Inspector #601 reviewed PSW #114 written statement signed on a specific date, regarding the incident, as the PSW was not available to be interviewed during the inspection. PSW #114 indicated in the written statement that on a specified date and time, PSW #114 was transferring resident #003 from their mobility device to bed. The PSW written statement, described the transfer in detail and indicated the resident identified pain in a specified area following the transfer.

Record review of resident #003's Safe Lift and Transfer assessment completed by RN #102 on a specified date, the resident was able to fully weight bear, follow instructions and required specific interventions to assist in and out of bed. The summary of assessment and plan indicated that resident #003 required specified assistance due to a severe risk of falls and injury. RN #102 also documented that resident #003 had specified weakness and was bed bound prior to admission to the Long-Term Care Home (LTCH).

Record review of Physiotherapist #124 assessment note on a specified date, identified that resident #003 was assessed as requiring specified assistance for transfers.

Record review of resident #003's plan of care interventions for transfers indicated that resident #003 required specified assistance for transfers including a specified transfer device.

During an interview on a specified date and time, the Physiotherapy Assistant (PTA) indicated to Inspector #601, that resident #003's plan of care for transfers was unchanged since admission to the home. The PTA also indicated that the specified transfer device was implemented by the Physiotherapist following the residents specified injury.

During separate interviews, RN #104, RPN #121 and PSW #139 indicated to Inspector #601 that resident #003's plan of care for transfers was unchanged since admission to the home. RN #104, RPN #121 and PSW #139 also indicated that the specified transfer device was added to resident #003's plan of care following the residents specified injury.

During an interview RPN #113 indicated to Inspector #601 that PSW #113 had reported the resident had specified pain on the same day, following the transfer. RPN #113 indicated not being aware that PSW #114 did not have a second person when transferring resident #003 until three days later. RPN #113 and Inspector #601 reviewed resident #003's plan of care in place at the time of the incident. RPN #113 indicated to

Inspector #601 that on the date of the incident, resident #003 required specified assistance or a mechanical lift for all transfers.

The licensee failed to ensure that resident #003's plan of care for all transfer was provided to the resident, as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident resident #009, as specified in the plan related to falls prevention.

Related to complaint log #012875-18:

On a specified date and time, the Ministry of Health Information Line received a complaint from resident #009's Substitute Decision Maker (SDM). The Complainant reported that resident #009 was admitted to the Long-Term Care Home (LTCH) on a specified date, and was discharged six days later. The Complainant also reported that the LTCH had notified them on a specific date, that resident #009 had sustained a specified injury due to falling out of bed. The Complainant indicated the resident had unexplained injuries. According to the Complainant, resident #009 had specific identified injuries. The Complainant also reported the resident had soiled specific identified body parts.

Record review of resident #009's progress notes for a specified date, documented by RN #102 identified the following information:
A Bedrail Risk Assessment structured progress note indicated that resident #009 had specified limitations. Resident was individually assessed, bedrail risk assessment completed, care plan was reviewed and updated. Fall preventions included on plan of care and bedrails removed on both sides. No bedrails were required due to risk for entrapment and falls. A Scott Fall Risk Assessment was completed, resident #009 had a risk score of 4.0 and that the care plan had been reviewed and was current.

Record review of resident #009's progress note on the date of admission indicated that, RN #140 applied a falls prevention device to resident #009's bed.

Record review of resident #009's progress notes for a specified date, documented by RN #110 identified the following information:
A Post Fall Assessment completed for incident occurring on a specified date. The fall assessment note indicated that resident #009 had sustained a specified injury and no other injuries. It was also indicated in the Post Fall Assessment, that the injury could

have been prevented with specified falls prevention devices in place. At the time of the incident, resident #009's falls prevention device sounded and the resident was found on the floor beside their bed. The progress note also indicated that resident #009 had been restless prior to the incident, was moving about their bed and that staff had attempted to settle resident prior to being discovered on the floor.

Record review of resident #009's progress notes for a specified date, documented by RN #102 identified the following information:
Will trial specific falls prevention interventions for resident #009. Power of Attorney (POA) was notified of the incident and that the resident had sustained a specific injury.

Record review of resident #009's admission care plan by Inspector #601 identified that resident #009 had physical limitations for bed mobility. The resident required specified assistance for transfers and positioning while in bed. Resident #009 had a goal to prevent falls and maintain safety in this environment and the care plan interventions were specifically identified.

During separate interviews on a specified date, PSW #138 and PSW #139 indicated to Inspector #601, that resident #009 would move about the bed and PSW #139 indicated that the resident required specified assistance to reposition the resident while in bed.

During separate interviews on a specified date RN #104 and RN #140 indicated to Inspector #601, that resident #009 did have previous admissions to the home. They both also indicated that resident #009 was at risk for falls and the plan of care for the resident included specified interventions.

The licensee failed to ensure that resident #009's measures for falls prevention were in place, as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in resident #010's plan of care related to falls prevention was provided to the resident, as specified in the plan.

Related to log #031616-18 for Critical Incident Report (CIR):

Inspector #601 reviewed Critical Incident Report (CIR) that was submitted to the Director on a specified date. The CIR indicated that resident #010, was found on the floor on a specific date and time and had sustained an injury. According to the CIR, the incident was reviewed and it was determined that the fall was the result of the resident receiving a

specific medication on that date. According to the CIR, resident #010's plan of care following the incident was updated to include to not administer the specific medication on a specified shift. Resident #010 was to receive the specified medication on an identified shift, when more staff were available to assist the resident.

Record review of resident #010's Medication Administration Record (MAR) for a specified time period, by Inspector #601 identified that the resident had a physician order to administer the specified medications:

Record review of resident #010's MAR by Inspector #601, identified that RN #110 documented that resident #010 received a specific identified medication on a specific date and time on five specific identified dates.

Record review of resident #010's care plan for falls prevention, transfers, continence and locomotion indicated that resident #010 was a high risk for falls due to history of falling and the resident would self-transfer. The following interventions were in place for a specified period of time:
-Specific identified medications are not to be administered on a specified shift.

During an interview, RN #104 indicated to Inspector #601 that resident #010 was receiving specific medical interventions due to a change in medical condition. RN #104 also indicated that on a specified date, resident #010's plan of care was updated following the incident. According to RN #104, resident #010 was not to be given the specific medication on the identified shift.

RN #110 was not available for interview during this inspection.

The licensee failed to ensure that resident #010's plan of care was followed, which was updated following a fall that resulted in the resident sustaining a fractured right hip. The updated plan of care indicated that staff were not to give the suppository on the night shift, was not followed for a specified period of time, on five identified dates, as specified in the plan.

On a specific date and time, resident #010 was observed by Inspector #601 and RN #104 awake in bed. Resident #010 did not have the specific falls prevention interventions in place on the left side of the bed. At this time, RN #104 indicated to Inspector #601 that resident #010 should have the fall mat on the floor next to the resident's bed.

Record review of resident #010's plan of care that was in place for a specified period of time that identified specific interventions for falls prevention, lifting and transferring were in place at the time of the incident.

During separate interviews on February 11, 2019, RN #104, RPN #121 and PSW #144 indicated that resident #010 was at high risk for falls and was receiving specific medical interventions due to a decline in their medical condition. RN #104, RPN #121 and PSW #144 also indicated that resident #010 required specific identified interventions as a falls prevention measure.

The licensee has failed to ensure that resident #010's falls prevention interventions were in place on a specified date, as indicated in the plan. [s. 6. (7)]

4. The licensee has failed to ensure that the care set out in resident #011's plan of care related to falls prevention was provided to the resident as specified in the plan.

Related to log #016595-18 for Critical Incident Report (CIR):

Inspector #601 reviewed Critical Incident Report (CIR) that was submitted to the Director on a specified date. The CIR indicated that on a specified date and time, PSW #115 had not provided resident #011 with the call bell when leaving the resident in their chair.

Record review of resident #011's post fall assessments for a specified period of time identified that resident #011 was a high risk for falls and had unsafe ambulation. Resident #011 had been found on the floor on a number of occasions during this same time period.

Record review of resident #011's care plan in place on a specified date, indicated that the resident was high risk for falls due to the failure to use assistive devices and other specific identified limitations. Resident #011 was able to recognize when they needed to use the washroom. Resident #011's falls interventions were identified which included the following:
-Encourage resident to call for assistance prior to self-transferring or attempting to toilet at every interaction;
-Ensure the call bell was within reach and in place as visual cue reminder;
-Staff to remind resident to use the call bell when they need help. Bed to be in low position and call bell in place;

Record review of resident #011's Falls Minimal Data Set (MDS) Resident Assessment Protocol (RAP) on a specified date, which indicated that resident #011 had a history of falls. The resident had an increased risk for falls related to specific identified areas of concern. Resident did have occasional falls usually related to independently transferring self in their bedroom and the care plan was aimed at avoiding complications. Staff were to address all needs of toileting, provide blanket before leaving resident in their room by themselves and ensure the resident had the call bell in their hand before leaving.

Record review of resident #011's post fall assessment progress note on a specified date documented by RPN #103, indicated the resident was specific identified limits due to severe pain. The resident was sent to the hospital for assessment. The progress note indicated that the resident was not provided with their call bell when they were put into their chair in their room. The resident reported they couldn't find the bell and "really had to go". Staff are now aware to put the call bell in the resident's hand when leaving them in their chair.

During an interview on a specified date and time, RPN #103 indicated that resident #011 was identified as a high risk for falls and that the call bell should have been within the resident's reach, on a specified date. RPN #103 reported that the resident was found on the floor near the entrance of the bedroom and that the call bell was located on the resident's bed. RPN #103 indicated asking PSW #115 about the call bell and that PSW #115 had reported to the RPN that they must have forgotten to give resident #011 the call bell.

During an interview on a specified date and time, the scheduling clerk #101 indicated at the time of the incident they were working as a laundry aide and they would assist staff with transfers, as needed. Scheduling clerk #101 indicated that PSW #115 had requested assistance to transfer resident #011 from their mobility device into their recliner chair in the resident's room, on a specified date. Scheduling clerk #101 indicated that they couldn 't verify if PSW #115 had given the resident the call bell before leaving the room.

During an interview on February 11, 2019, at 1510 hours, PSW #144 indicated that resident #011 would use the call bell to request assistance from staff for toilet use and the call bell was to be within reach at all times.

Record review of the licensee's investigation indicated that PSW #115 had assisted resident #011 to sit in their chair in their room, on a specified date and the PSW

confirmed that they did not give the resident their call bell. This resulted in a fall with injury.

The licensee failed to ensure that resident #011 had access to the call bell on a specified date and time, as a falls prevention measure, as specified in the plan. [s. 6. (7)]

***Additional Required Actions:***

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

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**WN #2: 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 are administered to residents in accordance with the directions for use specified by the prescriber.

Related to Log #003554-18 for CIR

On a specified date a CIR was submitted to the Director for incompetent treatment of a resident that results in harm or risk of harm to a resident. The CIR indicated that RPN #131 had conducted an audit for 25 days of their co-workers medication administration practice. It was reported to the Acting DOC and ED on a specified date, and not prior. The RPN provided their records and audit reports to the Acting DOC and ED. The Pharmacy Consultant was brought in to assist with the licensee's internal investigation. RPN #131 reported that they identified four specific residents who were to receive a specified medication twice daily, but did not always receive their medication as

prescribed despite the RPN's signing that the medication was administered.

Review of the licensee's internal investigation was completed by Inspector #623. The following information was identified:

RPN #131 audit notes from a specified time period, for a total of 25 days were reviewed and indicated the following:

Resident #014 –physician orders indicated a specified medication - 2 doses twice daily. The resident should have received 100 doses in the 25 days but only received 39 doses during that time. During that specified period of time, resident was receiving a specified antibiotic two times a day for 10 days, for treatment of a specified infection, all doses were administered of the antibiotic.

Resident #024 – physician orders indicated a specified medication - 2 doses twice daily. The resident should have received 100 doses in the 25 days but only received 56 doses.

Resident #025 – physician orders indicated a specified medication - 2 doses twice daily monitored for a total of 10 days. Resident #025 should have received 40 doses in the 10 days but only received 34 doses. For a specified period of time, resident was receiving a specified antibiotic two times a day for 10 days, for treatment of a specified infection, all doses were administered of the antibiotic.

Resident #026 – physician orders indicated a specified medication - 2 doses twice daily. The resident should have received 100 doses in the 25 days but only received 73 doses. During that specified period of time, resident was receiving a specified antibiotic two times a day for 10 days, for treatment of a specified infection, all doses were administered of the antibiotic.

RPN #130 - was identified as working during the 25 day audit period and failing to administer the specified medication as prescribed to resident #014 on eight specific identified dates. There was no documentation in the progress notes regarding administration, the eMAR was signed indicating the medication was administered, the audit records indicated that the doses were not administered. Total of 16 doses missed of the specified medication.

RPN #116 was identified as working during the 25 day audit period and failing to administer the specified medication as prescribed to the following identified residents:

Resident #025 on a specific date and time, two doses were signed as administered, no documentation in the progress notes regarding administration, the eMAR was signed indicating that the medication was administered, the audit records indicated that the doses were not administered. Total of two missed doses of the specified medication.

Resident #014 on seven specific identified dates, on each date two doses of the specific identified medication were signed as administered, no documentation in the progress notes regarding administration, the eMAR was signed indicating that the medication was administered, the audit records indicated that the doses were not administered. Total of 14 missed doses of the specified medication.

Resident #026 on three specific identified dates, on each date two doses of the specific identified medication were signed for as administered, no documentation in the progress notes regarding administration, the audit records indicated that the doses were not administered. Total of 6 doses missed of the specific medication.

Resident #024 on four specific identified dates, on each date two doses of the specific identified medication were signed as administered, no documentation in the progress notes regarding administration, the audit records indicated that the doses were not administered. Total of eight doses missed of the specified medication.

RPN #121 was identified as working during the 25 day audit period and failing to administer the specified medication as prescribed to resident #014, #024, on a specific date and time. For both residents, two doses were signed as administered on the eMAR, there was no documentation found in the progress notes regarding medication administration and the audit records indicated that the doses were not administered to resident #014 or #024. Total of four doses missed of the specific identified medication.

RPN #128 was identified as working during the 25 day audit period and failing to administer the specific identified medication as prescribed to resident #014, #024, and #026. On two specific identified dates and times for resident #014. On one specified date and time for resident #026 and resident #024. Each resident was to receive the specific identified medication, two doses. The medication was signed as administered on the eMAR, there was no documentation found in the progress notes regarding medication administration for each resident and the audit records indicated that the doses were not administered. Total of eight doses missed of the specified medication.

RPN #134 was identified as working during the 25 day audit period and failing to

administer a specific identified medication as prescribed to resident #014, on five specified dates and times, and for resident #024 on one specified date and time. For both residents, two doses were signed as administered on the eMAR, there was no documentation found in the progress notes regarding medication administration and the audit records indicated that the doses were not administered to resident #014 or #024. Total of 12 missed doses of the specific identified medication.

RPN#130, #116, #128 and #134 are no longer employed by the licensee and were therefore unable to be interviewed.

On a specific date and time, during an interview with Inspector #623, RPN #131 indicated that they were suspicious of certain staff not administering specific identified medications because they would discover the unopened container still on the medication cart on Monday morning after putting a new one in the cart on Friday and the medications would have been signed as administered. The specific identified medication for residents #014, #024, #025 and #026, has a counter on it and RPN #131 decided to make a note at the end of their shift as to what the number on the counter was. When they returned for their next shift, they would check the number at the beginning of the shift and check to see how many doses were supposed to be administered, how many were signed as administered and compare it to the counter on the inhaler. RPN #131 indicated that they kept this audit for 25 days and then took it to the Acting DOC and the ED as proof that residents were not receiving their medications. RPN #131 indicated that they were aware that there could be a negative outcome for the residents because of this, but did it anyway. RPN #131 indicated that they had reported their suspicion to the DOC in the past and had never gotten anywhere, so they took matters into their own hands.

On a specific date and time, during an interview with Inspector #623, the DOC indicated that the expectation is that all medications are to be administered to residents as they are prescribed. The DOC indicated that at the time this incident occurred, they were not employed in the home.

The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, when residents #014, #024, #025 and #026 were not administered the prescribed specific identified medication on multiple occasions over a 25 day time period, when signed as administered by RPN #130, RPN #116, RPN #121, RPN #128 AND RPN #134. [s. 131. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions**

**Specifically failed to comply with the following:**

**s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,**
**(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).**
**(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction is:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider

Related to Log #003554-18 for CIR

On a specific date and time a Critical Incident Report (CIR) was submitted to the Director

for incompetent treatment of a resident that results in harm or risk of harm to a resident. The CIR indicated the following:

RPN #131 had conducted an audit for a specified period of time totaling 25 days, of their co-workers medication administration practice. It was reported by RPN #131 to the Acting DOC and ED on a specified date, and not prior. The RPN provided their records and audit reports to the Acting DOC and ED. The Pharmacy Consultant was brought in to assist with the licensee's internal investigation. RPN #131 reported that they identified four specific residents who were to receive a specified medication twice daily, but did not always receive their medication as prescribed despite the RPN's signing that the medication was administered.

Resident #014 had specific diagnosis. Review of the physician orders indicated the following: specific identified medication - 2 doses twice daily. The resident should have received 100 doses in the 25 days but only received 39 doses during that time.

Resident #024 had specific diagnosis. Review of the physician orders indicated the following: specific identified medication - 2 doses twice daily. The resident should have received 100 doses in the 25 days but only received 56 doses.

Resident #025 had specific diagnosis. Review of the physician orders indicated the following: specific identified medication - 2 doses twice daily monitored for a total of 10 days. Resident #025 should have received 40 doses in the 10 days but only received 34 doses.

Resident #026 had specific diagnosis. Review of the physician orders indicated the following: specific identified medication - 2 doses twice daily. The resident should have received 100 doses in the 25 days but only received 73 doses.

On a specific date and time, during an interview with Inspector #623, RPN #131 indicated that they were suspicious of certain staff not administering specific identified medications because they would discover the unopened container still on the medication cart on Monday morning after putting a new one in the cart on Friday and the medications would have been signed as administered. The specific identified medication for residents #014, #024, #025 and #026, had a counter on it and RPN #131 indicated that they decided to make a note at the end of their shift as to what the number on the counter was. When they returned for their next shift, they would check the number at the beginning of the shift and check to see how many doses were supposed to be

administered, how many were signed as administered and compare it to the counter on the container. RPN #131 indicated that they kept this audit for 25 days and then took it to the Acting DOC and the ED as proof that residents were not receiving their medications. RPN #131 indicated that they were aware that during 25 day audit, the four residents were not always receiving their medications and three of the four residents were also treated with antibiotics for specific identified infections during this time. The RPN indicated that they were aware that there could be a negative outcome for the residents because of this, but did it anyway. RPN #131 indicated that they had reported their suspicion to the DOC in the past and had never gotten anywhere, so they took matters into their own hands. RPN #131 indicated that they were aware of the medication incident reporting process and did not follow it.

On a specific date and time, during an interview with Inspector #623, the ED indicated that the CIR was submitted, rather than medication incidents being completed at the recommendation of the Regional Director for Extendicare Assist. The incidents of missed medication, specifically the specific identified medication, for residents #014, #024, #025 and #026, over a period of 25 days, was identified as the result of monitoring that was conducted by RPN # 131. The RPN did not disclose the missed medications to the Acting DOC or ED until they had completed their independent audit. The ED indicated that the RPN wanted to be certain that they had solid evidence of medications not being administered, before they disclosed their suspicion to the management team. The ED indicated that the expectation of the home is that when the RPN initially suspected that there were medications not being administered as prescribed, that they would report this to the DOC and not wait for 25 days to complete an audit. Once the error was determined, there was no documented evidence based on a review of the medical records for residents #014, #024, #025 and #026, of any adverse effects or action taken following the discovery of the missed medications.

The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction is 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 SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that every medication incident involving a resident and every adverse drug reaction is 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 SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.***

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**Issued on this 8th day of March, 2019**

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

**Original report signed by the inspector.**