Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Original Public Report

Report Issue Date November 3, 2022
Inspection Number **2022_1551_0002**
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Corporation of the City of Cornwall

Long-Term Care Home and City
Glen-Stor-Dun Lodge

Lead Inspector
Michelle Edwards (655)

Michelle Edwards
Digitally signed by Michelle Edwards
Date: 2022.11.25 10:48:16 -05'00'
Inspector Digital Signature

Additional Inspector(s)
Mark McGill (733), Heath Heffernan (622), Sarah Stephens (740823)

INSPECTION SUMMARY

The inspection occurred on the following date(s): August 15, 17, 18, 19, 23, 24, 25, 26, 29, 30, 31, 2022; and September 1, 2, 5, and 6, 2022, on-site; and, September 7, 8, 9, 12, 13, 14, 16, 19, 2022; October 5, 2022, off-site.

This inspection was conducted concurrently with inspection 2022_1551_0001.

The following intake(s) were inspected:

- Log # 008542-22 – related to falls prevention and management,
- Log # 004733-22 – related to the care of a resident and falls prevention and management,
- Log # 004678-22 –related to a fall of a resident which resulted in injury; and,
- Log # 003133-22 – related to a fall of a resident which resulted in injury.

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Medication Management
- Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION – HOME TO BE SAFE, SECURE ENVIRONMENT

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 5

The licensee failed to ensure that the home was a safe environment for its residents, when resident #001 was not isolated from other residents when they were readmitted to the long-term care home.

In accordance with the Chief Medical Officer of Health's (CMOH) Directive (Directive #3), and the *COVID-19 guidance document for long-term care homes in Ontario* certain residents of a long-term care home (LTCH) who were readmitted to the LTCH, at the time that resident #001 was readmitted, were required to be isolated from other residents, to prevent the spread of COVID-19.

It was, however, reported to Inspector #655 that when resident #001 returned to the long-term care home, they were not isolated as required.

Inspector #655 reviewed the health care records belonging to resident #001 and found that two days after they had returned to the long-term care home, resident #001 had access to a common area in the home.

During an interview, it was confirmed to Inspector #655 that resident #001 would have been required to remain in isolation for a period of 10 days after returning to the long-term care home at the time, in accordance with Directive #3 and the guidance document. According to the staff member who was interviewed, a resident who was in isolation at that time was not to be given access to a common area in the home.

The failure to isolate resident #001 posed a risk to other residents related to the potential for COVID-19 transmission.

Sources: Resident #001's health care records, including progress notes; interviews with a family member of resident #001, and staff including registered nursing staff, IPAC Lead #107, and others; CMOH Directive #3 and *COVID-19 guidance document for long-term care homes in Ontario.*

[655]

WRITTEN NOTIFICATION - DOCUMENTION

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021 s. 6 (9) 1/LTCHA, 2007, s. 6 (9) 1

The licensee has failed to ensure that the provision of the care set out in the plan of care for residents #001, #004, #005, and #006 was documented.

Rationale and Summary

1. **The licensee failed to ensure that the provision of the care set out in the plan of care for resident #001 related to the resident's risk for falls was documented.**

Inspector #655 reviewed the health care records belonging to resident #001, including care plan and point of care (POC) records entered in two separate months.

In the care plan and POC records belonging to resident #001, staff were directed to ensure that a specific intervention related to resident #001's risk for falls was in place, and to ensure that related safety checks were performed in accordance with directions.

During an interview, it was indicated to Inspector #655 that staff were to sign-off as having completed the above-described care tasks in POC.

However, there was no documentation related to the monitoring and implementation of the specific intervention related to resident #001's risk for falls found in POC records entered during the first of two months reviewed. In addition, there were numerous gaps in the documentation found for the required safety checks.

This finding of non-compliance presents a potential risk related to the lack of information that would be accessible to others involved in the resident's care pertaining to safety concerns.

Sources: Resident #001's health care records, including: progress notes, care plan, and point of care documentation; family interview, and staff interviews, including interviews with PSW #133, RN #129, RN #124, RSS #102, and DON #109.

[655]

2. **The licensee has failed to ensure that the provision of the safety checks set out in the plan of care for residents #004, #005, and #006 was documented.**

In the progress notes, it was indicated that staff were to complete safety checks for residents #004, #005 and #006 on certain dates.

The documentation on Point of Care (POC) indicated that for resident #004, the safety checks were not documented on six dates. For resident #005, the safety checks were not documented on eight dates. For resident #006, the safety checks were not documented on six dates.

DON #109 stated that video surveillance indicated that staff had completed the safety checks for residents #004, #005 and #006; however, the staff had missed documenting the care.

This finding of non-compliance presents a potential risk related to the lack of information that would be accessible to others involved in the care of the above-identified residents pertaining to safety concerns.

Sources: Review of the safety check documentation on POC, progress notes, and interview of the DON #109 and other staff.

[622]

WRITTEN NOTIFICATION – FALLS PREVENTION AND MANAGEMENT

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 49 (2)

The licensee has failed to ensure that when resident #001 fell, a post-fall assessment was conducted using a clinically appropriate assessment instrument specifically designed for falls.

Rationale and Summary

Resident #001 fell and sustained an injury.

Inspector #655 reviewed the policy titled *Falls Prevention and Management Program* (RC-15-01-01), which was to be implemented by staff at the time of resident #001's fall.

Inspector #655 was unable to locate any record of a post-fall assessment having been conducted related to the fall of resident #001 in point click care (PCC), under the risk management tab, as required by the above-noted policy.

During an interview, a registered nurse indicated to Inspector #655 that they had responded to the fall of resident #001 on the day it occurred, but that they had not completed the post-fall assessment themselves. The registered nurse further indicated that they also were unable to locate a completed post-fall assessment tool related to the fall of resident #001.

The failure to complete the post-fall assessment instrument placed resident #001 at risk for a recurrent fall.

Sources: Resident #001's health care records, including risk management reports, progress notes, and assessments; a review of the related policy titled *Falls Prevention and Management Program* (RC-15-01-01); and, staff interviews, including interviews with: RN #117, RN #129, RN#124, and DON #109.

[655]

WRITTEN NOTIFICATION – PAIN MANAGEMENT

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10, s. 52 (2)

The licensee has failed to ensure that when resident #001's pain was not relieved by initial interventions, they were assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rationale and Summary

Pain management is a required program under s. 48 (1) (4) of Ontario Regulation 79/10 (O. Reg. 79/10). The program must provide for assessment and reassessment instruments (O. Reg. 79/10, 48 (2) (b)) and must include relevant, written policies, procedures, and protocols (O. Reg. 79/10, s. 30 (1) (1)).

In accordance with O. Reg. 79/10, s. 8 (1) (b), where the Act or Regulation requires the licensee of a long-term care home to have a policy or protocol in place, the licensee must ensure that the policy or protocol is complied with.

Specifically, the licensee failed to ensure that the policy titled "*Pain Identification and Management"* (RC-19-01-01) (last updated April, 2020) was complied with.

Resident #001 experienced new pain on two separate occasions.

On review of the health care records belonging to resident #001, Inspector #655 was unable to locate a completed *Pain Assessment* tool for resident #001 despite indicators that resident #001's pain was not relieved by initial interventions, including periods of time when a breakthrough pain medication was given to resident #001 on three or more consecutive days.

During an interview, DON #109 indicated to Inspector #655 that required pain assessments were generally not being completed for residents on a consistent basis in the long-term care home at the time.

This posed a risk to residents, including resident #001, related to the potential for persistent pain; and, related to the potential for persistent effects of pain and pain related medications on a resident.

Sources: Resident #001's health care records, including: progress notes, physician orders, electronic Medication Administration Records (eMARs), and assessments; a related policy,

titled *Pain Identification and Management* (RC-19-01-01), interviews with a family member of resident #001 and staff, including: RN #117, RN #124, RN #129, RD #134, NP #135, and DON #109.	
[655]	

WRITTEN NOTIFICATION - NUTRITION CARE AND HYDRATION PROGRAMS

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 68 (2) (e) (i)

The licensee has failed to ensure that the weight monitoring system, to measure and record with respect to each resident a monthly weight, was complied with.

Rationale and Summary

In accordance with Ontario Regulation 79/10, s. 8 (1) b, where the Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place a system, the licensee is required to ensure that the system is complied with.

Inspector #655 reviewed the health care records belonging to resident #001, including an electronically recorded history of resident #001's weight taken over the course of the resident's stay at the long-term care home.

On review of the records, Inspector #655 found that there was a four-month period during which time there had been no record of resident #001's weight.

During an interview, a staff member indicated to Inspector #655 that staff normally obtain a resident's weight and enter it into the electronic health record system monthly, enabling the registered dietitian (RD) to generate reports for the purpose of identifying any residents with significant weight loss. At the same time, the staff member indicated that they also could not find a record of resident #001's weight during the above-noted four-month timeframe. According to the staff member, monthly weights were not consistently obtained for residents at that time, due to an active outbreak in the long-term care home.

Because of this non-compliance, RD #134 would not have been able to accurately assess resident #001 or monitor their weight, potentially delaying intervention. As a result, resident #001's health was at risk.

Sources: Resident #001's health care record, including records related to the resident's weight history, oral intake, and hospital stays; and interviews with staff including PSW #133, RN #124, and RD #134.

[655]	

COMPLIANCE ORDER [CO#01] INTEGRATION OF ASSESSMENTS, CARE

NC#06 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: LTCHA, 2007 s. 6 (4) a

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with LTCHA, 2007, s. 6 (4) a

The licensee shall:

1. **Review, analyze, and evaluate any existing procedures (such as, but not limited to, methods of communication)** that are in place at the long-term care home related to the collaboration of staff and other care providers in the assessment of a resident's care needs to ensure that assessments are effectively integrated.

2. **Ensure that the review, analysis and evaluation described in step (1):**

   a) Includes consideration of procedures that are in place at the point of care transition – specifically, at the time of a resident's readmission to the long-term care home following a period of hospitalization,
   b) Includes a review of resident #001's health care records specifically to identify potential deficiencies in existing procedures; and,
   c) Includes, at a minimum, a review of methods of communication used between internal and external care providers, and between internal staff, to ensure the accurate and timely exchange of information concerning a resident's status and/or care needs.

3. **Ensure that any required changes or improvements identified** because of the review required under steps (1) to (2) of this order are **implemented.** This process must be done with reference to a resident recently readmitted to the long-term care home from hospital, if there is one.

A written record must be kept of everything required under step (1), (2), and (3) of this compliance order, until the Ministry of Long-term Care has deemed that the licensee has complied with this order.

Grounds

Non-compliance with: LTCHA, 2007, s. 6 (4) a

The licensee has failed to ensure that the staff and others involved in the different aspects of care of resident #001 collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Rationale and Summary

1. **When resident #001 returned to the long-term care home from the hospital, staff and others involved in the different aspects of resident #001's care did not effectively collaborate with each other in the assessment of resident #001 so that their assessments of resident #001's care needs were consistent with each other.**

Over the course of the inspection, Inspector #655 reviewed a document titled *Discharge Summary (Final Report)* (the discharge summary). The discharge summary was related to the above-noted hospital stay of resident #001.

According to the discharge summary, resident #001 was admitted to the hospital for a specific reason, but other diagnoses had affected the resident's length of stay. The other diagnoses affecting the resident's stay were identified. There were new orders and new medications prescribed for resident #001 in the discharge summary.

The hospital discharge summary was found to have been initialed by one of resident #001's attending care providers in the home.

However, there was otherwise no record of the new order or the new medication prescriptions referred to above on any of resident #001's health care records.

During an interview, one of resident #001's attending care providers indicated to Inspector #655 that they had not been aware of resident #001's condition as described in the hospital discharge summary; or the new medication prescriptions which would have been clinically indicated by the identified condition. At the same time, they indicated to Inspector #655 that hospital records are not always received promptly at the long-term care home; or, when they are, are not always accessible to the most appropriate care providers when needed – such as at the time of medication reconciliation. (See NC #08 for additional information).

2. **Staff and others involved in the different aspects of resident #001's care did not effectively collaborate with each other in the assessment of resident #001 so that**

their assessments were integrated and were consistent with and complemented each other, related to the resident's nutritional status.

On review of resident #001's health care records, Inspector #655 found no indication that Registered Dietitian (RD) #134 was made aware of certain, relevant, changes in resident #001's condition when resident #001 returned to the long-term care home following the previously noted hospital stay.

During an interview, a staff member indicated to Inspector #655 that there was no indication that the RD had received the relevant information regarding resident #001's condition on review of their records. The same staff member indicated to Inspector #655 that when a resident is diagnosed with the condition that affected resident #001, the RD may consider implementing an intervention- something that had not been considered for resident #001.

In addition, and as described in NC #05, resident #001's weight was not obtained or recorded by staff for a period of four months. Resident #001 had experienced weight loss over a period of time.

3. **When resident #001 experienced a change in condition, the assessment of resident #001 by hospital care providers was not integrated into the assessment of resident #001 at the time of the change.**

As described above, resident #001 had been identified in hospital discharge records to have been diagnosed with other diagnoses affecting the length of resident #001's hospital stay. According to the hospital discharge records, resident #001's condition remained at the time of resident #001's return to the long-term care home, despite interventions provided in hospital.

On review of resident #001's health care records, Inspector #655 found that resident #001 was reported to have experienced an acute change in condition approximately 11 days after they returned to the long-term care home from the hospital.

In a progress note entered that day (11 days after the hospital stay), resident #001's condition at the time was described.

During an interview, a registered nurse recalled the above-noted change in resident #001's status. At the same time, the registered nurse indicated to Inspector #655 that the resident's observed change in status was such that they implemented additional supervision of the resident at the time. The registered nurse indicated to Inspector #655 that, at the time, they had assessed resident #001 to be in pain, and administered pain medication to the resident.

Neither the physician or nurse practitioner had been notified of resident #001's condition that day.

On the following day, resident #001 was taken to hospital post-fall.

According to the more recent hospital records, other diagnoses were again noted to have affected the resident's length of stay in hospital, including those identified in the previous hospital discharge summary, as described above.

The licensee has failed to ensure that staff and others involved in the different aspects of the care of resident #001 – including, but not limited to hospital based care providers - collaborated with each other in the assessment of resident #001's status and care needs, so that their assessments were integrated and were consistent with each other when resident #001 returned to the long-term care home from hospital, and then in assessing resident #001's nutritional status, and subsequent change in condition that occurred after they returned to the long-term care home from hospital.

This finding of non-compliance presented a risk to resident #001's health and wellbeing related to an untreated condition and risk for falls. Resident #001 did fall approximately 12 days after they returned to the long-term care home- an incident which resulted in actual harm to the resident.

Sources: Resident #001's electronic and hard copy health care records, including hospital discharge records, eMARs, prescriber orders, laboratory results, and progress notes; and interviews with staff including RN #117, RN #124, RD #134, NP #135, MD #136, and DON#109.

[655]

This order must be complied with by February 1, 2023

COMPLIANCE ORDER [CO#02] DUTY OF LICENSEE TO COMPLY WITH PLAN

NC#07 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: FLTCA, 2021 s. 6 (7)/ LTCHA, 2007, s. 6 (7)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with **FLTCA, 2021 s. 6 (7)/LTCHA, 2007, s. 6 (7)**

The licensee shall:

1. **Survey all direct care staff** for the purpose of identifying any members of direct care staff who require additional education related to how to access a resident's written plan of care. Step (1) must be completed for the purpose of ensuring that all direct care staff can familiarize themselves with a resident's plan of care and can comply with it.

2. **Educate** any staff member who was identified through the survey described under step (1) as requiring additional education related to how to access a resident's plan of care, as well as the requirements to familiarize themselves with a resident's plan of care and to comply with it.

A written record must be kept of everything required under step (1) and (2) of this compliance order, until the Ministry of Long-term Care has deemed that the licensee has complied with this order.

Grounds

Non-compliance with: FLTCA, 2021 s. 6 (7)/LTCHA, 2007, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #'s 001, 004, 005, 006, 009, and 011 as specified in the plan.

Rationale and Summary

1. **The licensee failed to ensure that a specific intervention related to falls prevention was implemented for resident #001 as specified in the plan.**

The Director, under the Long-Term Care Homes Act, 2007, received information in which it was alleged that a required falls prevention intervention was not consistently implemented for resident #001 by staff in the home.

Inspector #655 reviewed the health care records belonging to resident #001, including care plan and progress notes.

According to resident #001's care plan, the specified falls prevention intervention was to be in place for resident #001 at all times.

In two separate progress notes, it was stated that the same fall prevention intervention was found *not* to be in place, as required at the time.

During interviews, two members of registered nursing staff indicated to Inspector #655 that there were times when the same required intervention had not been implemented, including

the two separate incidents that were described in the above-noted progress notes. At the same time, one of the registered nurses recalled a third, separate incident, in which the required falls prevention intervention was again found not to be in place, as required.

The licensee failed to ensure that care set out in resident #001's plan of care was provided as specified in the plan of care when a specified falls prevention intervention was not consistently implemented for resident #001 as required.

As a result, resident #001 was at risk for a recurrent fall.

Sources: Resident #001's health care records, including progress notes, care plan and point of care (POC) documentation; interview with a family member of resident #001, and interviews with staff including: PSW #133, RN #129, RN #124, and RSS #102.

[655]

2. **The licensee failed to ensure that the Dementia Observation System (DOS) tools set out in the plan of care were completed for residents #004, #005, and #006 as specified in the plan.**

Progress notes indicated that staff were to complete DOS tools for residents #004, #005, and #006 on certain dates.

DOS assessments located on Point of Care (POC) for resident #004 indicated that DOS assessments were not completed on four of the specified dates. For resident #005, DOS assessments were not completed on six of the specified dates. For resident #006, DOS assessments were also not completed on six of the specified dates.

Over the course of the inspection, it was determined that the DOS tool was included in the plan of care. As such, the plan of care was not followed for residents #004, #005, and #006 when the DOS assessments were not completed.

By not completing the Dementia Observation System (DOS) tool, staff would not be able to accurately analyse and develop a plan for the resident's behaviour using the data collected from the DOS tool, placing them at risk.

Sources: Dementia Observation System (DOS) tool, Progress notes, Resident Services Supervisor #102, and other staff, including PSW #128.

[622]

3. The licensee failed to ensure that the care set out in the plan of care was provided to resident #009 as specified in the plan, related to the monitoring of resident #009's skin condition.

Staff were required to take pictures of resident #009's skin at a prescribed frequency, for the purpose of monitoring and assessing the resident's skin condition, as ordered by resident #009's nurse practitioner.

However, on review of resident #009's health care records, including medication administration record (MAR), Inspector #740823 found a total of 30 dates in which there was no record of registered staff having taken the required picture as specified in the MAR.

During an interview, a member of the registered nursing staff confirmed that there should have been a picture taken of resident #009's skin condition, as set out in the resident's plan of care.

Sources: Medication Administration Record orders, progress notes, skin and wound assessments, interview with a member of registered nursing staff.

[740823]

4. **The licensee failed to ensure that that the care set out in the plan of care for resident #011 was provided to the resident as specified in the plan, related to resident #011's transfer needs.**

On a specified dated, resident #011 fell during a transfer.

According to the plan of care, resident #011 required assistance with transfers. However, at the time of the above-described incident, resident #011 was not transferred with the level of assistance that was identified in the resident's plan of care.

As a result of this fall, the resident experienced pain. There was moderate impact and risk to resident #011.

Sources: a related **Critical Incident Report**, Plan of Care for resident #011, Interview with Resident Services Supervisor #102.

[733]

Over the course of the inspection, members of direct care staff (including two PSWs) indicated to inspectors that they did not know how to access a resident's electronic care plan in order to locate information related to a resident's plan of care.

This order must be complied with by February 1, 2023

COMPLIANCE ORDER [CO#03] MEDICATION MANAGEMENT SYSTEM

NC#08 Compliance Order pursuant to FLTCA, 2021, s.154(1)2
Non-compliance with: LTCHA, 2007 s. 114 (3) (a)

The Inspector is ordering the licensee to:

FLTCA, 2021, s. 155 (1) (a) do anything, or refrain from doing anything, to achieve compliance with a requirement under this Act

Compliance Order [FLTCA 2021, s. 155 (1)]

The Licensee has failed to comply with LTCHA, 2007, s. 114 (3) (a)

The licensee shall:

1. **Immediately, ensure that RN #124 is provided with education** related to the existing requirement of a preparatory independent doublecheck of a prepared medication-reconciliation form at the time of a resident's readmission to the long-term care home, as outlined in the relevant policies.

2. **Evaluate existing written policies and protocols** related to the medication-reconciliation process for resident's returning to the long-term care home from the hospital. The purpose of the evaluation is:

    a) To ensure the written policies and protocols contain **clear directions** for registered nursing staff and others involved in the medication-reconciliation process, and,

    b) To ensure that the written policies and protocols are **consistent with evidence-based practices, and if there are none, prevailing practices.**

At a minimum, the Director of Nursing, the Medical Director, the pharmacy service provider and at least one member of the registered nursing staff must be involved in the evaluation of the licensee's medication reconciliation processes.

If the licensee's written policies and protocols related to medication-reconciliation are updated as a result of the evaluation required under step (2), ensure that all registered nursing staff, and others involved in medication reconciliation receive education on the changes.

3. **Develop and implement monitoring and remedial processes**. At a minimum:
    a) Adherence to the licensee's medication-reconciliation policies and protocols by nursing staff will be measured when any resident is readmitted to the long-term care home from the hospital, for a period of four weeks; and,

b) The licensee shall ensure that relevant corrective action is taken if deviations from the established policies and protocols by staff are identified; or, if errors, or medication omissions are identified.

A written record must be kept of everything required under step (1), (2), and (3) of this compliance order, until the Ministry of Long-term Care has deemed that the licensee has complied with this order.

Grounds

Non-compliance with: O. Reg. 79/10 *s. 114 (3) (a)*

The licensee has failed to ensure that written policies developed for the medication management system related to the process of medication-reconciliation were implemented by staff when resident #001 returned to the long-term care home following a period of hospitalization.

Rationale and Summary

Specifically, the licensee failed to ensure that the following policies related to the medication management system were implemented:

- *Medication Reconciliation - Long Term Care Homes* (Policy # 2.7.1) (last revised December, 2016); and,
- *Processing Physician Medication Reviews* (Policy #2.6) (last revised November, 2015).

The above-noted policies, together, outline the procedural steps for the completion of medication-reconciliation at the time of a resident's readmission to the long-term care home following a period of hospitalization.

During an interview, DON #109 confirmed that in accordance with the licensee's policies, a second nurse is required to complete a preparatory independent doublecheck of resident's prepared *"Re-Admission Medication and Reconciliation Orders"* form before the medications are reviewed and authorized by a prescriber. Available source documents would be referred to at multiple times throughout the medication-reconciliation process.

Discharge Summary (Final Report)

Resident #001 returned to the long-term care home following a period of hospitalization post-fall.

Over the course of the inspection, Inspector #655 reviewed a document titled *Discharge Summary (Final Report)* (the discharge summary), including a list of new medication prescriptions related to the above-noted hospital stay of resident #001.

According to the discharge summary, resident #001 was admitted to the hospital post-fall, but other diagnoses had affected the resident's length of stay. There were new orders and new medications that were prescribed related to the other diagnoses.

Over the course of the inspection, Inspector #655 found no record of the above-noted order or the new medication prescriptions, as recommended by hospital care providers in the hospital discharge summary, on any other health care record belonging to resident #001.

Re-Admission Medication Reconciliation Orders

Inspector #655 reviewed the "Re-Admission Medication Reconciliation Orders" form (the medication reconciliation form) related to the above-described readmission of resident #001. Inspector #655 did not find any record of the above-noted order or the new medication prescriptions on the medication reconciliation form.

In addition to the above, there was no indication that a preparatory independent doublecheck had been completed by a second nurse before the reconciled medication list had been approved by a prescriber. The "2nd Nurse Signature for Preparing Physician Review" section of the form was incomplete on all seven pages of the form, with no date and no signature identified.

During an interview, a registered nurse described the procedural steps involved in completing the medication-reconciliation process for a resident, at the point of a resident's readmission to the long-term care home following a period of hospitalization. The process described by the registered nurse did not include a preparatory independent doublecheck of the prepared medication reconciliation form by a second nurse. According to the same registered nurse, when a nurse does perform a check, this is documented by way of a recorded signature in the allotted space on the form.

The licensee failed to ensure that written policies developed for the medication management system related to the process of medication-reconciliation (*Medication Reconciliation - Long Term Care Homes* (Policy # 2.7.1), and *Processing Physician Medication Reviews (*Policy #2.6)) were implemented by staff when the *prepared* medication reconciliation form was not doublechecked by a nurse when resident #001 was readmitted to the long-term care home.

The medications as well as an order for laboratory tests were not included on the medication reconciliation form; and therefore, they were not considered for authorization by the appropriate prescriber in the long-term care home. The resident did not receive the identified medications intended to treat the other diagnoses which had affected resident #001's hospital stay, resulting in a risk for negative health outcome for resident #001.

The symptoms associated with the other diagnoses had the potential to place resident #001 at an increased risk of falls.

Resident #001 fell approximately 12 days after they returned to the long-term care home from hospital. The fall resulted in actual harm to resident #001.

Sources: Resident #001's electronic and hard copy health care records, including: hospital discharge records, eMARs, prescriber orders, laboratory results, and progress notes; and interviews with staff including: registered nursing staff, NP #135, MD #136, and DON#109.

This order must be complied with by February 1, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

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 or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West,9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

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