Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
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Original Public Report

Report Issue Date: April 30, 2024
Inspection Number: 2024-1402-0002
Inspection Type: Critical Incident Follow up
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
Long Term Care Home and City: Norfinch Community, North York

Lead Inspector	Inspector Digital Signature
Yannis Wong (000707)	Yannis Wong Digitally signed by Yannis Wong Date: 2024.05.01 10:25:48 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 8-12, 15, 2024

The following intakes were inspected:

- Intake: #00108445 - Follow-up - CO #001 from 2024-1402-0001 related to O. Reg. 246/22, s. 140 (2)
- Intake: #00111181 [Critical Incident: #2918-000005-24] - related to a medication incident

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1402-0001 related to O. Reg. 246 / 22, s. 140 (2) inspected by Yannis Wong (000707)

The following Inspection Protocols were used during this inspection:

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medication management system

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246 / 22, s. 123 (1)
Medication management system
s. 123 (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

The licensee has failed to comply with the home's medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

In accordance with O. Reg. 246 / 22, s. 11 (1) (b), the licensee was required to ensure the policies developed for the medication management system were complied with. Specifically, the licensee failed to ensure staff complied with the "New Medication Orders" policy, last revised November 30, 2023, when the physician did not sign the medication reconciliation form.

Rationale and Summary
Medication reconciliation forms were completed when a resident returned from hospital after two separate hospital stays. The forms were verified with the physician and processed as a telephone order. On both forms, the prescriber's signature was missing.

The home's policy, "New Medication Orders" directs the prescriber to co-sign all telephone orders upon their next visit to the home.

A physician stated they had not seen the resident as they had been re-hospitalized during the dates of their visits. The physician indicated their expectations were that documents that needed to be reviewed by them were prepared on a clipboard for them to sign during their visits. If the form was in the resident's chart while the resident was not in the home, then they would not have been signed. The Director of Care (DOC) stated the physician's telephone orders would be in the resident's chart. The DOC stated the physician reconciled the medications after the resident was readmitted from the hospital via telephone and should have been verified with the physician's signature on the next physician visit even if the resident had been re-hospitalized.

Failure to ensure the prescriber signed off on the telephone orders may increase the risk of errors during medication reconciliation.

Sources: Resident clinical records; home's policy 4.2 "New Medication Orders", last revised November 30, 2023; interviews with physician and DOC. [000707]