Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 20, 2015	2015_168202_0012	T-2939-15	Critical Incident System

Licensee/Titulaire de permis

MARKHAVEN, INC.
54 PARKWAY AVENUE MARKHAM ON L3P 2G4

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

MARKHAVEN, INC.
54 PARKWAY AVENUE MARKHAM ON L3P 2G4

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

VALERIE JOHNSTON (202)

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): August 04, 05, September 01, 03, 2015.

An identified Critical Incident Report (CIS, revealed that resident #01 had received resident #02's medications in error on an identified date, during an identified medication pass. Resident was transferred to hospital that same day and passed away an identified number of days later.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care, registered nursing staff, personal support workers.

During the course of the inspection, the inspector reviewed clinical health records, reviewed the home's policies related to medication administration and observed the medication administration cart.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On an identified date, the MOHLTC received a critical incident report (CIS), submitted by the home indicating that resident #01 had received resident #02's medications in error

on an identified date. The CIS report provided the following details of the incident that occurred on the identified date:

-At an identified time, resident #01 health declined acutely for an identified period of time,

-RPN #101, checked his/her medication cart and discovered that resident #01's medications were still in the cart after an identified medication pass, and realized he/she had given the wrong medication to resident #01,

-At an identified time, on the same day, the RN called the physician, who then ordered the resident to be monitored and called again, if the resident continued to decline,

-As resident #01's health continued to decline, an identified RN called the physician who then ordered the resident to be sent to hospital for further assessment,

-The resident remained in hospital for an identified number of days, during which time the resident's health continued to deteriorate,

-The resident passed away at hospital on an identified date and coroner was called to investigate the events leading up to the resident's death.

An amendment was later made to the above mentioned CIS by the home on an identified date, which indicated that the Coroner arrived at the facility to investigate the incident. The CIS further indicated that at the time of the Coroner's investigation, and in a verbal conversation with the DOC, the Coroner had deemed the incident as accidental and that resident #01 passed away of identified complications as a result.

The following information has been obtained as a result of a critical incident inspection conducted on August 04, 05, and September 01, 03, 2015:

A review of the home's Medication Pass-Procedure policy, dated June 23, 2014, directs registered staff with the following procedures relevant to the medication pass:

1. "The Eight Rights of Medication Administration" according to the College of Nurses of Ontario for registered staff must be observed when administering medications to avoid errors. The nurse or care provider is responsible for, the right client, right medication, right dose, right route, right time, right reason, right site and right frequency.
2. Avoid conversation and attempt to minimize distractions when preparing medications.

3. Medication administration is a continuous process and should always be completed for the specific resident before moving on to another resident's medication or request.
4. The nurse or staff who prepares a medication for administration, or prepares an injection, must administer it.
5. Approach the resident when all medications to be given are prepared. Verify the resident's identity using two identifiers.
6. Once the medication administration is completed for all residents, check each drawer and the next package to be given. Ensure that there is no package marked for the current pass time left in the resident drawers.

An interview with RPN #101 indicated that on an identified date, during an identified medication pass, resident #02's medication was administered to resident #01 in error.

RPN #101 revealed that he/she had pre-poured resident #02's medications at an identified approximate time and before an identified meal. The RPN indicated that he/she had prepared resident #02's medications and placed the mixture of medications in resident #02's labelled bin inside the medication cart. The RPN indicated that the pre-poured medications were to be administered to resident #02 after the resident had completed his/her meal.

RPN #101 further revealed that at the same approximate time, he/she closed the medication cart and began assisting residents in the dining room.

RPN #101 revealed that during the meal, at an approximate time, PSW #106 became argumentative and questioned him/her about his/her judgement. RPN #101 indicated that PSW #106 became increasingly angry, such that RPN #101 chose to end the conversation with PSW #106 by refraining to listen to PSW #106.

RPN #101 further revealed in an interview that while he/she was assisting to feed a resident in the dining room, he/she began to feel "upset and really bad". RPN #101 stated that once the meal had completed, he/she then called the RN supervisor #105 for assistance, who responded to the RPN, stating that he/she was busy and would not be able to assist for an identified approximate amount of time.

RPN #101 indicated that after calling RN #105 for assistance and knowing that it would be a few minutes before the RN would arrive, he/she decided to resume the medication pass. RPN #101 confirmed that it was at the time that the medication pass resumed, that it was the time that he/she had mistakenly taken resident #02's pre-poured medications

and administered them to resident #01.

RPN #101 further indicated that he/she was unaware of the medication error that he/she made at the time of administration and that it was not until an identified time on the same day, when resident #01's health acutely declined that he/she knew a medication error had been made.

Resident #01’s clinical records, and interviews with the DOC, RN #105 and RPN #101, confirmed that resident #01 had been administered seven identified medications at an approximate identified time and identified date, that had not been prescribed to the resident.

RN #105 and RPN #101 indicated in interviews that when RPN #101 returned to resident #01's home area, at an identified approximate time, that resident #01' health had acutely declined. As a result of resident #01’s deterioration and the discovery that a medication error had been made, the RN indicated that the on-call physician was contacted right away.

RN #105 indicated that the attending physician had ordered the RN to monitor resident #01 and administer the resident's regular scheduled medications.

RN #105 further revealed that as a result of resident #01’s continual decline, the above mentioned scheduled medications could not be administered to the resident and as a result, 911 was called and the resident was transferred to hospital.

A review of resident #01’s clinical records indicated that the resident had been admitted to hospital on an identified date, with an identified diagnosis and received treatment for inappropriate ingestion of medications. The resident passed away an identified number of days later and on an identified date.

The DOC confirmed that the above medications had been prescribed to resident #02 and administered to resident #01 in error and that resident #02 received his/her regular scheduled medications when the error was discovered.

The DOC revealed in an interview that the above mentioned medication error had been fully investigated by the home, and as a result of the home’s investigation confirmed that the medication error occurred as a result of RPN #101 being upset and distracted at the time of incident.

The DOC further revealed in a subsequent interview one month after the initial interview, that after further investigation conducted at the home, the home discovered that RPN #101 had pre-poured resident #02's medications on an identified date and time, placed them in the medication and assisted residents in the dining room. The DOC confirmed that when RPN #101 resumed the medication pass, RPN #101 had taken resident #02's prepared medications from resident #02's labelled bin inside the medication cart and administered them to resident #01 in error.

The severity of the non-compliance and the severity of the harm and risk of further harm is actual. On an identified date, RPN #101 administered resident #02's pre-poured medications and administered them to resident #01 in error. As a result, resident #01's condition deteriorated, resulting in an emergency transfer to hospital in order to receive treatment for inappropriate ingestion of medications. The resident was admitted to hospital with an identified diagnosis and had passed away an identified number of days later and on an identified date.

The scope of the non-compliance is isolated to resident #01.

A review of the compliance history revealed the following non-compliance related to the Long-Term Care Homes Act, O.Reg 79/10., s. 131 (1):
A voluntary plan of correction (VPC) was previously issued for O.Reg. 79/10. s. 131 (1) during a Resident Quality Inspection on April 25, 2014, under Inspection #2014_109153_0002, whereby, resident #0041 had been administered and identified medication every six hours for an identified three month time period, with no physician order. [s. 131. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 23rd day of October, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALERIE JOHNSTON (202)
Inspection No. / No de l'inspection :	2015_168202_0012
Log No. / Registre no:	T-2939-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 20, 2015
Licensee / Titulaire de permis :	MARKHAVEN, INC. 54 PARKWAY AVENUE, MARKHAM, ON, L3P-2G4
LTC Home / Foyer de SLD :	MARKHAVEN, INC. 54 PARKWAY AVENUE, MARKHAM, ON, L3P-2G4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LAURA BURNS

To MARKHAVEN, INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. The plan should include, but not be limited to ensuring the following:

1. Registered staff do not pre pour medications.

2. Registered staff administer medications, in accordance to the College of Nurses of Ontario professional practice Standards and Guidelines:

a) The right client/resident
b) The right medication/drug
c) The right dose/amount
d) The right route/method
e) The right time
f) The right reason
g) The right site
h) The right frequency

4. Registered staff avoid conversation and attempt to minimize distractions when preparing and administering medications, as in accordance to the home's Medication Pass-Procedure policy, dated June 23, 2014.

5. All registered staff in the home receive education in the administering of medications as in accordance with the College of Nurses of Ontario professional practice Standards and Guidelines.

The plan shall be submitted to valerie.johnston@ontario.ca by November 06, 2015. The plan is to include the required tasks, the person(s) responsible for completing the tasks and the time lines for completion.

Grounds / Motifs :

1. 1. On an identified date, the MOHLTC received a critical incident report (CIS), submitted by the home indicating that resident #01 had received resident #02's medications in error on an identified date. The CIS report provided the following details of the incident that occurred on the identified date:

-At an identified time, resident #01 health declined acutely for an identified period of time,

-RPN #101, checked his/her medication cart and discovered that resident #01's medications were still in the cart after an identified medication pass, and realized he/she had given the wrong medication to resident #01,

-At an identified time, on the same day, the RN called the physician, who then ordered the resident to be monitored and called again, if the resident continued to decline,

-As resident #01's health continued to decline, an identified RN called the physician who then ordered the resident to be sent to hospital for further assessment,

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An amendment was later made to the above mentioned CIS by the home on an identified date, which indicated that the Coroner arrived at the facility to investigate the incident. The CIS further indicated that at the time of the Coroner's investigation, and in a verbal conversation with the DOC, the Coroner had deemed the incident as accidental and that resident #01 passed away of identified complications as a result.

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medications.
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RPN #101 further indicated that he/she was unaware of the medication error that he/she made at the time of administration and that it was not until an identified time on the same day, when resident #01's health acutely declined that he/she knew a medication error had been made.

Resident #01's clinical records, and interviews with the DOC, RN #105 and RPN #101, confirmed that resident #01 had been administered seven identified medications at an approximate identified time and identified date, that had not been prescribed to the resident.

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The severity of the non-compliance and the severity of the harm and risk of further harm is actual. On an identified date, RPN #101 administered resident #02's pre-poured medications and administered them to resident #01 in error. As a result, resident #01's condition deteriorated, resulting in an emergency transfer to hospital in order to receive treatment for inappropriate ingestion of medications. The resident was admitted to hospital with an identified diagnosis and had passed away an identified number of days later and on an identified date.

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A voluntary plan of correction (VPC) was previously issued for O.Reg. 79/10. s. 131 (1) during a Resident Quality Inspection on April 25, 2014, under Inspection #2014_109153_0002, whereby, resident #0041 had been administered and identified medication every six hours for an identified three month time period, with no physician order. [s. 131. (1)] (202)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 11, 2015

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

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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
Direction de l'amélioration de la performance et de la conformité
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 20th day of October, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Valerie Johnston

Service Area Office /
Bureau régional de services : Toronto Service Area Office