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

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

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

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
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 19, 2018	2018_462600_0013	017785-18	Complaint

Licensee/Titulaire de permis

Providence St. Joseph's and St. Michael's Healthcare
3276 St. Clair Avenue East TORONTO ON M1L 1W1

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

Providence Healthcare
3276 St. Clair Avenue East SCARBOROUGH ON M1L 1W1

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

GORDANA KRSTEVSKA (600)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 16, 17, 18, and August 29, 2018.

During this inspection a Critical Incident System (CIS) report was inspected regarding a medication incident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Care Manager (RCM), Resident Care Supervisor (RCS), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Record release department staff from Michael Garron Hospital, and Substitute Decision Maker (SDM).

The following Inspection Protocols were used during this inspection:
Medication
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #001 was protected from abuse by anyone and free from neglect by the licensee or staff in the home.

For the purposes of the definition of neglect, O. Reg. 79/10, s. 5, defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A complaint was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, regarding a concern raised by resident #001's Substitute Decision Maker (SDM) when resident #001 was sent for further assessment on a specified date for change of their condition and was diagnosed with an identified condition. The resident passed away a few days later.

A review of resident #001's health record indicated the resident was admitted to the home on a specified date with identified medical diagnoses. The resident was on a treatment for their condition and was to be checked every shift.

A review of the resident's physician order indicated the resident was not prescribed any medication containing an identified substance and the medication administration record (MAR) for an identified month, indicated the resident had not received medication that contained the substance from a specified date.

A review of the resident's progress notes for an identified date, showed no entry notes on day shift from 0700 to 1500 hours. The progress notes for the evening shift recorded at 2245 hours indicated the evening nurse, Registered Practical Nurse (RPN) #110 identified that at supper time the resident's condition was noted to be changed more than usual. The nurse checked the resident's vital signs (VS) which were within the resident's range, put the resident in bed and continued monitoring the resident. There was no further documentation as to whether the resident was monitored after supper time.

An interview with RPN #110 indicated that on an identified date they were starting medication rounds and passing by resident #001's room when they found the resident to be dozing in the wheelchair. The RPN stated that was unusual for the resident because usually any other time the resident would be awake and would complain about either the staff, a roommate, a pain, anything, but not to be a sleep. The RPN indicated they called resident #001's name a few times loudly, until finally they opened their eyes, and asked the resident to take them to the dining room. Later on when the RPN returned to the dining room, they observed the resident had their head leaned on the table and were sleeping. The RPN one more time indicated that this was not what this resident would

usually do. The RPN woke the resident again by more intensive shaking. The RPN stated PSW #106 had also noted that the resident was more sleepy than usual. The RPN encouraged the resident to eat the soup and went to bring the equipment to check the resident's VS. When the RPN came back to the dining room, the resident was leaned on the table again, sleeping. The RPN further stated the resident's VS were within the resident's range so the RPN was thinking the resident must have been very tired. The RPN shook the resident again as resident was continuously falling asleep. The staff assisted the resident to bed and 15 minutes later, when the RPN started the bed hour medication, the PSW had called the RPN to check resident #001's altered skin integrity as they were providing night care to the resident. The RPN and PSW #106 confirmed they had not observed the resident's face when they were providing care and assessing the skin as the resident was positioned on their side. The RPN stated the resident usually was awake at that time, watching TV but at that time the resident was sleeping and that something was odd for the resident. The RPN also confirmed that they felt something was not right that the resident was asleep so much however they had not monitored the resident's VS or checked the level of consciousness. The RPN also indicated later on they went to check on the resident a few times. However, the RPN confirmed that they had not checked resident's VS and they had not contacted the RN for their concern because of the resident's change in condition. The RPN also confirmed they had not communicated their concern to the upcoming registered staff from the night shift.

An interview with the night Registered Nurse (RN) #108 indicated that their shift routine was after they listen to the report, around 2345 hour they will go and check the residents. When they went in resident #001's room, the RN noted the resident was snoring very loud, which was unusual for them. The RN called PSW #107 to reposition the resident thinking by exposing the airways the resident would not snore. As per the RN, they told the PSW to keep an eye on the resident and they will come back and check on the resident once they complete their rounds on third and fourth floor. The RN confirmed that they had not checked the resident's vital signs at that time. The RN also confirmed that they were not able to come back to the resident until around 0430 hours when they found the resident with change in their condition and changed values of the vital signs. Then the RN called the physician, called the SDM and sent the resident to the hospital.

During the interviews with PSW #106 and PSW #107 both confirmed that they checked on the resident, and the resident was sleeping and they did not want to disturb the resident so they did not reposition them when they noticed the resident remained in the same position. At a specified hours PSW #107 documented in PSW's documentation sheet on the question: " Did you observe any changes or safety concern with the

resident's sleep pattern" confirming "Yes", however they did not notify the RN that the resident who usually is independent in bed mobility, remained on the same side all the time.

During an interview the Director of Care (DOC) acknowledged that the evening RPN should have contacted the RN when the RPN identified the change in resident #001's condition, that something was not right with resident #001. Further the DOC stated the RPN should have checked the vital signs at least before she left and to communicate the concerns to the night nurse. The DOC also acknowledged that the night RN should have checked the vital signs when they noticed the resident's sleeping pattern was changed. The DOC also acknowledged that there was a pattern of inaction by the staff in the case of resident #001's change in their condition. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remained in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

A complaint was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, regarding a concern raised by resident #001's Substitute Decision Maker (SDM) when resident #001 was sent for further assessment on a specified date for change of their condition and was diagnosed with an identified condition. The resident passed away a few days later.

The home submitted a CIS report to the MOHLTC on an identified date related to an

incident that caused an injury to resident #001 for which the resident was sent to a hospital and which resulted in significant change in the resident's health status. The amended CIS report from a specified date, indicated that the home had conducted an internal investigation as to how resident #001 sustained the identified condition. The home's investigation record indicated that RPN #105 who administered morning medications on the unit probably made a medication error during administering medications.

Review of the resident's Medication administration record (MAR) for an identified month indicated resident #001 was to have the identified prescribed medications in the morning.

Interview with RPN #105 indicated that on the specified date they were called to work in the morning so they were behind on the morning medication administration. In an interview the RPN stated that few hours after breakfast they parked the medication cart in front of the dining room and had administered medication to all residents that were in the dining room from one side of the unit, except for some of the residents who were staying in their rooms for breakfast. The RPN confirmed that they pre-poured the medications for the residents in separate medication cups. From the dining room the RPN took the medication in their hands carrying them to the residents' rooms. The RPN confirmed the medications were not in their original labelled packages provided by the pharmacy before they administered the medication to the residents. The RPN further stated they administered medication based on which side the residents' rooms were located and which hand they held the medication cups. The RPN also confirmed that they did not have the original labelled pouches with them and the medication cups were not labelled.

Interview with the Resident Care Manager (RCM) confirmed the registered staff is to have their medication cart and the MAR next to the resident while administering medication to the resident. The medication must stay in the original packages prior to the administration to the resident. The RCM acknowledged the RPN did not have the original labelled package provided by the pharmacy when administered to the identified resident. [s. 126.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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).

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 no drug was used by or administered to a resident in the home unless the drug has been prescribed for the resident.

A complaint was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, regarding a concern raised by resident #001's Substitute Decision Maker (SDM) when resident #001 was sent for further assessment on a specified date for change of their condition and was diagnosed with an identified condition. The resident passed away a few days later.

The home submitted a CIS report to the MOHLTC on an identified date, related to an incident that caused an injury to resident #001 for which the resident was sent to a hospital and which resulted in significant change in the resident's health status. The hospital notified the home that the initial laboratory analysis revealed increased level of an identified substance in resident #001's specimen.

The amended CIS report from an identified date, indicated that the home had conducted an internal investigation as to how the identified substance was found in resident #001's body despite the fact that the resident was not ordered any medication containing that substance. The home's investigation record indicated that RPN #105 who administered morning medication on the unit probably had made medication error. The rationale for this was that another identified resident received medication containing the identified substance in their medication treatment while resident #001 does not have any medication that has the identified substance in their content.

Review of the resident's Medication administration record (MAR) for an identified month, indicated resident #001 was to receive the identified prescribed medications.

A review of the physician's order confirmed the above mentioned medication.

Resident #002 resided in the room across from an identified room where resident #001 resided. A review of resident #002's MAR for the same month, indicated among other medications resident #002 was to receive a specified medication with an identified dose (one cap by mouth twice daily).

Interview with RPN #105 indicated that they were not regular staff on the floor and on the identified date, they were called to work on an identified floor as they were not in a full time position at the home. According to the RPN's statement after breakfast they parked the medication cart in front of the dining room and administered medication to all residents that were in the dining room from the west side of the unit, except for the residents who were staying in their rooms for breakfast. The RPN confirmed that they removed the medications for resident #001 out of the labelled pouches and put them in a medication cup. The RPN then removed the medications for resident #002 and poured medication in another cup along with an identified solution in another cup. They left the medication cups for resident #002 on one side of the medication cart. The RPN went to administer the medications to the residents down the hall. They carried the medication in their hands. The cups were not labelled, and the pouches with information were not with the RPN. When the RPN arrived at the end of the hallway, they entered resident #001's room first, left the cup on the over-bed table and told the resident they would be back to administer the medication. Then the RPN went to resident #002, administered medication and came back to resident #001. There they administered medication to resident #001. The RPN confirmed the medications were not in their original labelled packages provided by the pharmacy before they administered the medication to resident #001 and resident #002. The RPN further stated they tried to remember to administer medication based on which side the residents' rooms were and which hand they held the medication cups. The RPN also confirmed that they were not aware of what medication resident #001 received as they did not look into the cup, and they did not have the pouches or the MAR with them. The RPN also said that they were very tired when they came to work, and was not aware if they might have switched the medications.

During an interview, resident #002 was not able to recall if they had any concerns regarding medication administration on the identified date.

An interview with the RCM stated on the identified date, after resident #001 was sent for further assessment earlier that morning, the clinic called and notified the home that laboratory analysis of resident #001's specimen indicated high level of an identified substance. The home initiated internal investigation to find out how an identified substance was found in resident #001's body.

The home investigation record review indicated the RPN #105 who administered morning medication on the unit probably had made medication error. The rational for this was that resident #002 received medication containing the identified substance in their medication treatment while resident #001 does not have any medication that has the identified substance in their content.

An interview with the Administrator indicated they could not think of any other way of how resident #001 would have the identified substance in their body, unless by having a specified mediation by mistake. The Administrator also said that the RPN #105 was very sensitive during their investigation, indicating they were not sure what they administered to resident #001. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

During the observation on three identified residents' home areas inspector #600 observed the following:
During the observation on an identified unit inspector observed RPN #102 administering medication to resident #004. Medication were administered in crushed consistency with apple sauce.

A review of resident #004's plan of care indicated the resident was not on modified texture diet, and physical assistance as needed. A review of the physician's order indicated no directions to the staff the medications to be altered or to be given with food.

An interview with the RPN #102 indicated the resident had received identified medications. The RPN reviewed the physician's order and resident's MAR and acknowledged the physician had not given direction that the medication was to be given crushed with apple sauce. The RPN stated they did not follow the direction as they though the resident would take the medication faster if they were crushed and mixed with the food. [s. 131. (2)]

3. On an identified date, around 0930 hours, RPN #101 was observed administering medication to resident #003. In an interview with the RPN #101 after they administered the medication to the resident the RPN indicated they administered the identified medication:

When the RPN was asked about the directions for use of the identified medication specified by the physician, they said the family requested one of the identified medication to be given with food, but was not able to locate the information. The RPN reviewed the MAR and the physician's order and confirmed that there was no order for the identified medication to be given with food. Further they acknowledged that the physician order directed staff to mix the other medication with a specific beverage. The RPN acknowledged they did not administer the medications to resident #002 in accordance with the direction specified by the physician.

Interview with RN #103 indicated the RPNs are expected to double check and follow the physician's orders transcribed in the MAR for safe medication administration.

In an interview the Director of Care (DOC) confirmed that the RPN and all registered staff are expected to administer medications to residents in accordance with the directions for use specified by the physician. [s. 131. (2)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 - to ensure that no drug was used by or administered to a resident in the home unless the drug has been prescribed for the resident, - to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

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 18th day of October, 2018

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GORDANA KRSTEVSKA (600)
Inspection No. / No de l'inspection :	2018_462600_0013
Log No. / No de registre :	017785-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 19, 2018
Licensee / Titulaire de permis :	Providence St. Joseph's and St. Michael's Healthcare 3276 St. Clair Avenue East, TORONTO, ON, M1L-1W1
LTC Home / Foyer de SLD :	Providence Healthcare 3276 St. Clair Avenue East, SCARBOROUGH, ON, M1L-1W1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pat Colucci

To Providence St. Joseph's and St. Michael's Healthcare, 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 19 (1) of the LTCHA.

The licensee shall prepare, submit and implement a plan to ensure every resident is protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The plan should include but not limited to:
a) Development and implementation of a process for communication among direct care staff including:
i. monitoring of residents with change in condition,
ii. conducting assessments, communicating findings, applying intervention, and documenting the outcomes of the interventions for residents who experience a change in a condition,
b) A description of the training and education that will occur related to prevention of abuse and neglect including:
i. what constitute abuse and neglect including the definition as per the LTCHA, 2007, failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and inaction or a pattern of inaction that jeopardizes the health, safety or well-being of residents,
ii. the home's policy for abuse and neglect,
iii. to ensure that all direct care staff is trained, understand and confirm an understanding of the different types of abuse and neglect and common forms of abuse and neglect in long-term care.

Please submit the written plan for achieving compliance for inspection #2018_462600_0013 to Gordana Krstevska, LTC Homes Inspector, MOHLTC, by email to: TorontoSAO.generalemail@ontario.ca by October 15, 2018.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. 1. The licensee has failed to ensure resident #001 was protected from abuse by anyone and free from neglect by the licensee or staff in the home.

For the purposes of the definition of neglect, O. Reg. 79/10, s. 5, defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A complaint was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, regarding a concern raised by resident #001's Substitute Decision Maker (SDM) when resident #001 was sent for further assessment on a specified date for change of their condition and was diagnosed with an identified condition. The resident passed away a few days later.

A review of resident #001's health record indicated the resident was admitted to the home on a specified date with identified medical diagnoses. The resident was on a treatment for their condition and was to be checked every shift.

A review of the resident's physician order indicated the resident was not prescribed any medication containing an identified substance and the medication administration record (MAR) for an identified month, indicated the resident had not received medication that contained the substance from a specified date.

A review of the resident's progress notes for an identified date, showed no entry notes on day shift from 0700 to 1500 hours. The progress notes for the evening shift recorded at 2245 hours indicated the evening nurse, Registered Practical Nurse (RPN) #110 identified that at supper time the resident's condition was noted to be changed more than usual. The nurse checked the resident's vital signs (VS) which were within the resident's range, put the resident in bed and continued monitoring the resident. There was no further documentation as to whether the resident was monitored after supper time.

An interview with RPN #110 indicated that on an identified date they were starting medication rounds and passing by resident #001's room when they found the resident to be dozing in the wheelchair. The RPN stated that was unusual for the resident because usually any other time the resident would be awake and would complain about either the staff, a roommate, a pain, anything, but not to be a sleep. The RPN indicated they called resident #001's name a few times loudly, until finally they opened their eyes, and asked the resident to take them to the dining room. Later on when the RPN returned to the dining room, they observed the resident had their head leaned on the table and were sleeping. The RPN one more time indicated that this was not what this resident would usually do. The RPN woke the resident again by more intensive shaking. The RPN stated PSW #106 had also noted that the resident was more sleepy than usual. The RPN encouraged the resident to eat the soup and went to bring

the equipment to check the resident's VS. When the RPN came back to the dining room, the resident was leaned on the table again, sleeping. The RPN further stated the resident's VS were within the resident's range so the RPN was thinking the resident must have been very tired. The RPN shook the resident again as resident was continuously falling asleep. The staff assisted the resident to bed and 15 minutes later, when the RPN started the bed hour medication, the PSW had called the RPN to check resident #001's altered skin integrity as they were providing night care to the resident. The RPN and PSW #106 confirmed they had not observed the resident's face when they were providing care and assessing the skin as the resident was positioned on their side. The RPN stated the resident usually was awake at that time, watching TV but at that time the resident was sleeping and that something was odd for the resident. The RPN also confirmed that they felt something was not right that the resident was asleep so much however they had not monitored the resident's VS or checked the level of consciousness. The RPN also indicated later on they went to check on the resident a few times. However, the RPN confirmed that they had not checked resident's VS and they had not contacted the RN for their concern because of the resident's change in condition. The RPN also confirmed they had not communicated their concern to the upcoming registered staff from the night shift.

An interview with the night Registered Nurse (RN) #108 indicated that their shift routine was after they listen to the report, around 2345 hour they will go and check the residents. When they went in resident #001's room, the RN noted the resident was snoring very loud, which was unusual for them. The RN called PSW #107 to reposition the resident thinking by exposing the airways the resident would not snore. As per the RN, they told the PSW to keep an eye on the resident and they will come back and check on the resident once they complete their rounds on third and fourth floor. The RN confirmed that they had not checked the resident's vital signs at that time. The RN also confirmed that they were not able to come back to the resident until around 0430 hours when they found the resident with change in their condition and changed values of the vital signs. Then the RN called the physician, called the SDM and sent the resident to the hospital.

During the interviews with PSW #106 and PSW #107 both confirmed that they checked on the resident, and the resident was sleeping and they did not want to disturb the resident so they did not reposition them when they noticed the resident remained in the same position. At a specified hours PSW #107

documented in PSW's documentation sheet on the question: " Did you observe any changes or safety concern with the resident's sleep pattern" confirming "Yes", however they did not notify the RN that the resident who usually is independent in bed mobility, remained on the same side all the time.

During an interview the Director of Care (DOC) acknowledged that the evening RPN should have contacted the RN when the RPN identified the change in resident #001's condition, that something was not right with resident #001. Further the DOC stated the RPN should have checked the vital signs at least before she left and to communicate the concerns to the night nurse. The DOC also acknowledged that the night RN should have checked the vital signs when they noticed the resident's sleeping pattern was changed. The DOC also acknowledged that there was a pattern of inaction by the staff in the case of resident #001's change in their condition. [s. 19. (1)]

The severity of the issue was determined to be a level 3 as there was actual harm/risk to resident #001, the scope was determined to be a level 1 as it was isolated to resident #001 and the previous compliance history was determined to be a level 4 as there was related noncompliance with an ongoing VPC or CO that included:
- #2017_420643_0008 issued June 19, 2017,
- #2016_484646_0012 issued February 16, 2017. (600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Order / Ordre :

The licensee must be compliant with r. 126.

The licensee shall prepare, submit and implement a plan to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

Specifically the licensee must:
a) Provide education and training to all registered staff regarding safe medication administration.
b) Implement an on-going auditing process to ensure that:
I. registered staff administer medication to a resident from the original package and not pre-pour medication prior to administering to the resident,
II. registered staff to administer medication to one resident at a time,
III. if the resident remains in their room, registered staff must follow the practice of safe medication administration,
d) Maintain a written record of education and audits conducted. The written record must include the date, the resident's name, staff member's name, the name of the person completing the audit and the action taken as a result of the audit outcome.

The Licensee shall prepare, submit and implement a plan for complying with Orders 1 - 2 for inspection #2018_462600_0013, and identify who will be responsible for completing all of the tasks identified in the Orders and when the Orders will be complied with. The plan is to be submitted to Gordana Krstevska, LTC Homes Inspector, MOHLTC, by email to: TorontoSAO.generalemail@ontario.ca by October 15, 2018.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that drugs remained in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

A complaint was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, regarding a concern raised by resident #001's Substitute Decision Maker (SDM) when resident #001 was sent for further assessment on a specified date for change of their condition and was diagnosed

with an identified condition. The resident passed away a few days later.

The home submitted a CIS report to the MOHLTC on an identified date related to an incident that caused an injury to resident #001 for which the resident was sent to a hospital and which resulted in significant change in the resident's health status. The amended CIS report from a specified date, indicated that the home had conducted an internal investigation as to how resident #001 sustained the identified condition. The home's investigation record indicated that RPN #105 who administered morning medications on the unit probably made a medication error during administering medications.

Review of the resident's Medication administration record (MAR) for an identified month indicated resident #001 was to have the identified prescribed medications in the morning.

Interview with RPN #105 indicated that on the specified date they were called to work in the morning so they were behind on the morning medication administration. In an interview the RPN stated that few hours after breakfast they parked the medication cart in front of the dining room and had administered medication to all residents that were in the dining room from one side of the unit, except for some of the residents who were staying in their rooms for breakfast. The RPN confirmed that they pre-poured the medications for the residents in separate medication cups. From the dining room the RPN took the medication in their hands carrying them to the residents' rooms. The RPN confirmed the medications were not in their original labelled packages provided by the pharmacy before they administered the medication to the residents. The RPN further stated they administered medication based on which side the residents' rooms were located and which hand they held the medication cups. The RPN also confirmed that they did not have the original labelled pouches with them and the medication cups were not labelled.

Interview with the Resident Care Manager (RCM) confirmed the registered staff is to have their medication cart and the MAR next to the resident while administering medication to the resident. The medication must stay in the original packages prior to the administration to the resident. The RCM acknowledged the RPN did not have the original labelled package provided by the pharmacy when administered to the identified resident.[s. 126.]

The severity of this issue was determined to be a level 3 with actual harm/risk to resident #001, the scope was determined to be a level 1 as it related only to resident #001, and the previous compliance history was determined to be a level 2 as there was unrelated noncompliance in the last 36 months. (600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

Order # / Ordre no : 003

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

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 must be compliant with O. Reg. 79/10, s. 131.

Specifically the licensee must:
a) Provide education and training to all registered staff regarding safe medication administration.
b) Implement an on-going auditing process to ensure that:
i. registered staff apply safety check practices prior to administering medication to a resident from the original package,
ii. registered staff administer medication to one resident at the time,
iii. if a resident remains in a room, registered staff follow the practice of safe medication administration.
d) Maintain a written record of education and audits conducted. The written record must include the date, the resident's name, staff member's name, the name of the person
completing the audit and the action taken as a result of the audit outcome.

The Licensee shall maintain a written record to identify who will be responsible for completing all of the tasks identified in the Orders and when the Orders will be complied with.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug has been prescribed for the resident.

A complaint was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date, regarding a concern raised by resident #001's Substitute Decision Maker (SDM) when resident #001 was sent for further

assessment on a specified date for change of their condition and was diagnosed with an identified condition. The resident passed away a few days later.

The home submitted a CIS report to the MOHLTC on an identified date, related to an incident that caused an injury to resident #001 for which the resident was sent to a hospital and which resulted in significant change in the resident's health status. The hospital notified the home that the initial laboratory analysis revealed increased level of an identified substance in resident #001's specimen.

The amended CIS report from an identified date, indicated that the home had conducted an internal investigation as to how the identified substance was found in resident #001's body despite the fact that the resident was not ordered any medication containing that substance. The home's investigation record indicated that RPN #105 who administered morning medication on the unit probably had made medication error. The rationale for this was that another identified resident received medication containing the identified substance in their medication treatment while resident #001 does not have any medication that has the identified substance in their content.

Review of the resident's Medication administration record (MAR) for an identified month, indicated resident #001 was to receive the identified prescribed medications.

A review of the physician's order confirmed the above mentioned medication.

Resident #002 resided in the room across from an identified room where resident #001 resided. A review of resident #002's MAR for the same month, indicated among other medications resident #002 was to receive a specified medication with an identified dose (one cap by mouth twice daily).

Interview with RPN #105 indicated that they were not regular staff on the floor and on the identified date, they were called to work on an identified floor as they were not in a full time position at the home. According to the RPN's statement after breakfast they parked the medication cart in front of the dining room and administered medication to all residents that were in the dining room from the west side of the unit, except for the residents who were staying in their rooms for breakfast. The RPN confirmed that they removed the medications for resident #001 out of the labelled pouches and put them in a medication cup. The RPN then removed the medications for resident #002 and poured medication in

another cup along with an identified solution in another cup. They left the medication cups for resident #002 on one side of the medication cart. The RPN went to administer the medications to the residents down the hall. They carried the medication in their hands. The cups were not labelled, and the pouches with information were not with the RPN. When the RPN arrived at the end of the hallway, they entered resident #001's room first, left the cup on the over-bed table and told the resident they would be back to administer the medication. Then the RPN went to resident #002, administered medication and came back to resident #001. There they administered medication to resident #001. The RPN confirmed the medications were not in their original labelled packages provided by the pharmacy before they administered the medication to resident #001 and resident #002. The RPN further stated they tried to remember to administer medication based on which side the residents' rooms were and which hand they held the medication cups. The RPN also confirmed that they were not aware of what medication resident #001 received as they did not look into the cup, and they did not have the pouches or the MAR with them. The RPN also said that they were very tired when they came to work, and was not aware if they might have switched the medications.

During an interview, resident #002 was not able to recall if they had any concerns regarding medication administration on the identified date.

An interview with the RCM stated on the identified date, after resident #001 was sent for further assessment earlier that morning, the clinic called and notified the home that laboratory analysis of resident #001's specimen indicated high level of an identified substance. The home initiated internal investigation to find out how an identified substance was found in resident #001's body.

The home investigation record review indicated the RPN #105 who administered morning medication on the unit probably had made medication error. The rational for this was that resident #002 received medication containing the identified substance in their medication treatment while resident #001 does not have any medication that has the identified substance in their content.

An interview with the Administrator indicated they could not think of any other way of how resident #001 would have the identified substance in their body, unless by having a specified mediation by mistake. The Administrator also said that the RPN #105 was very sensitive during their investigation, indicating they were not sure what they administered to resident #001. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

During the observation on three identified residents' home areas inspector #600 observed the following:
During the observation on an identified unit inspector observed RPN #102 administering medication to resident #004. Medication were administered in crushed consistency with apple sauce.

A review of resident #004's plan of care indicated the resident was not on modified diet, and physical assistance as needed. A review of the physician's order indicated no directions to the staff the medications to be altered or to be given with food.

An interview with the RPN #102 indicated the resident had received identified medications. The RPN reviewed the physician's order and resident's MAR and acknowledged the physician had not given direction that the medication was to be given crushed with apple sauce. The RPN stated they did not follow the direction as they though the resident would take the medication faster if they were crushed and mixed with the food. [s. 131. (2)]

3. On an identified date, around 0930 hours, RPN #101 was observed administering medication to resident #003. In an interview with the RPN #101 after they administered the medication to the resident the RPN indicated they administered the identified medication:

When the RPN was asked about the directions for use of the identified medication specified by the physician, they said the family requested one of the identified medication to be given with food, but was not able to locate the information. The RPN reviewed the MAR and the physician's order and confirmed that there was no order for the identified medication to be given with food. Further they acknowledged that the physician order directed staff to mix the other medication with a specified beverage. The RPN acknowledged they did not administer the medications to resident #002 in accordance with the direction specified by the physician.

Interview with RN #103 indicated the RPNs are expected to double check and follow the physician's orders transcribed in the MAR for safe medication

administration.

In an interview the Director of Care (DOC) confirmed that the RPN and all registered staff are expected to administer medications to residents in accordance with the directions for use specified by the physician. [s. 131. (2)] The severity of this issue was determined to be a level 3 with actual harm/risk to resident #001, the scope was determined to be a level 1 as it related only to resident #001, and the previous compliance history was determined to be a level 2 as there was unrelated noncompliance in the last 36 months. (600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 19th day of September, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Gordana Krstevska

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