Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 18, 2019	2019_610633_0014	013729-19, 013730-19, 014635-19, 014892-19, 015888-19, 017181-19	Complaint

Licensee/Titulaire de permis

Saint Luke's Place
1624 Franklin Blvd. CAMBRIDGE ON N3C 3P4

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

Saint Luke's Place
1624 Franklin Boulevard CAMBRIDGE ON N3C 3P4

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

SHERRI COOK (633), KRISTAL PITTER (735), VALERIE GOLDRUP (539)

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): September 12, 13, 16-20, 24-27, 30, October 1, 2, 2019.

The following intakes were completed during this inspection:

Log #015888-19- Follow Up (FU) to compliance order (CO) #001 from inspection 2019_739694_0013 related to abuse.
Log #'s 013729-19, 013730-19, 014635-19, 014892-19- Complaints related resident care, responsive behaviours and alleged abuse.
Log #017181-19- critical incident (CI) related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), the Administrator, the Director of Resident and Personal Care (DORPC), the Director of Finance and Corporate Services (DFC), the Director of Human Resources (DHR), the Associate Director of Care (ADOC), MediSystems Team Lead (MTL), a Pharmacist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the staffing and scheduling co-ordinator, a RPN student, family members and residents.

In addition, the inspector(s) observed resident care, resident and staff interactions and medication administration. The plan of care for the identified residents, the home's medication incidents and related documentation, and the home's relevant policies were also reviewed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

9 WN(s)
5 VPC(s)
2 CO(s)
1 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2019_739694_0013	539

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	Légende 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. (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 :

On three specified dates, a number of residents did not receive their medications in

accordance with the directions for use specified by the prescriber.

A) Multiple complaints were received by the Ministry of Long-Term Care (MLTC) related to a medication incident that occurred on a specific date and time.

The home's records showed that a number of residents did not receive any of their medications on a specific date and time. A number of other residents did not receive their scheduled medications until up to two hours after the prescribed time. The accountable RN had not completed the medication pass. The missed medications were for specific diagnoses and symptom management.

Residents interviewed were unable to recall this incident related to their level of impaired cognition.

The plan of care for all identified residents and the home's dated reports showed the medications were missed and the impact on three specific residents.

Specific medication administration tasks were completed at identified times. Several registered staff stated that once these tasks had been completed the on-coming registered staff member was responsible for medication administration to the residents.

On a specific date, a number of residents did not receive their medications as prescribed. This was related to a scheduled medication pass which had not been completed by the RN.

B) A second medication incident was identified which occurred on a specific date. Multiple residents did not receive their scheduled medications within one-hour of the prescribed time. The same accountable RN had initiated the medication pass however, they did not complete the pass and multiple medications had to be given by the on-coming registered staff member.

The home's dated records showed that a number of residents did not receive their scheduled medications until two and three hours from the prescribed time. The missed medications were for specific diagnoses and symptom management.

The residents interviewed were unable to recall this incident.

The plan of care for all identified residents and the home's dated reports showed the

medications were missed and the impact on three specific residents.

On an identified date, a number of residents did not receive their medications as prescribed. This was related to a scheduled medication pass that had not been completed by the same RN.

C) A third medication incident occurred on a specific date, which involved the same RN. An identified resident did not receive a specific medication as prescribed.

The home's records related to this incident were inconsistent and incomplete. An assessment was not documented, the medical doctor (MD) was not contacted and there was no MD order obtained.

Multiple registered staff, the Associate Director of Care (ADOC) and the Director of Resident and Personal Care (DORPC) confirmed that the expectation was that medications were to be given as directed by the order and within an hour of the prescribed time. The two identified medication passes should have been completed by a specific time and were not. The DORPC acknowledged that a medication pass may have impact on the on-coming registered staff member and the resident's next scheduled dose. The DORPC confirmed that a doctor should have been contacted and directions and/or orders obtained in a situation where a medication was late and it was close to the next prescribed time. Nurses were expected to follow the standards of the College of Nurses of Ontario (CNO).

On three specific dates, the home's records showed that a number of residents did not receive their medications as prescribed by the same accountable RN.

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. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

The licensee has failed to ensure that every medication incident was documented together with a record of the immediate actions taken to assess and maintain the resident's health.

On three specific dates, a number of residents did not receive their scheduled medications as prescribed.

The plan of care for all identified residents and the home's records did not document an assessment of the residents and the actions taken.

Multiple registered staff said that in response to a medication incident, the resident should be checked, and they would document this. The ADOC said that the home's medication incident reports included a box to document the actions taken and they and/or the DORPC reviewed the reports for completeness, however, specific dated reports did not include an assessment of the resident and the immediate actions taken that were documented together as required.

2. The identified resident’s plan of care and the home's dated records showed that three specific medication incidents, which involved a number of residents, were not correctly analyzed and documented. Corrective action was not taken as necessary. The records also showed that the residents' SDM and MD were not always notified.

Documentation on the home's medication incident reports and a specific related report was incomplete, inaccurate and not timely related to two medication incidents. There was no follow up documentation by the DORPC. Another medication incident was not self reported, and not reported by staff. The DORPC acknowledged that a situation where multiple residents did not receive their medication as ordered would be considered a medication incident and the home's process should have been followed in response. The home's records showed that this did not occur.

The ADOC and DORPC said that in response to a medication incident the SDM and MD were notified. An investigation and staff reflections were completed and staff counseling and education was provided. The home's records showed that there was no investigation and no corrective action taken related to three specific medication incidents.

The home's records showed that the same RN was accountable for medication passes on two dates and a medication incident on another date, however, a specific report did not include their medication errors. No strategies or trends were identified to prevent recurrence.

The home's policy related to medication incidents and near misses was not followed.

Multiple registered staff, the Team Lead for MediSystem Pharmacy, the Pharmacist, the ADOC and DORPC confirmed that the home's medication incident process was inconsistent, inaccurate and documentation was incomplete.The home’s policy and process related to medication incidents lacked transparency.

The DORPC stated that the expectation for registered nurses was that they practiced in accordance with the CNO and the home's policies and standards.

3. O. Reg. 79/10 s. 120(3) states that the home's pharmacy service provider is required to participate in risk management and quality improvement activities which included the review of medication incidents.

The home's quarterly medication incidents for a specific period showed that all medication incidents, which included both nursing and pharmacy related errors, were not sent to the pharmacy by the home. The home's policy related to medication incidents and near misses was not followed. The registered staff said they did not have access to the on-line Medication Incident Reporting System (MIRS) to report the incidents themselves.

A specific report was based on inconsistent and incomplete medication incident documentation and a lack of analysis. The Pharmacist said they were not involved in the preparation and analysis of the home's quarterly medication incidents.

The MediSystems Team Lead and the Pharmacist both said the online MIRS was available to the home. The tool was comprehensive however, not in use. They confirmed the process and content related to a medication incident and the home's records showed that this did not occur.

The licensee has failed to ensure that the pharmacy service provider participated in risk management and quality improvement activities which included reviewing the home's medication incidents.

4. O Reg. 79/10 s. 144 (a)(b) states that the written policies and protocols for the home's medication management system, which included the policy and protocol related to medication incidents, are to be developed, implemented, evaluated and updated in accordance with evidence-based practices and reviewed by the Pharmacist.

The home's medication incident policy was revised at the time of inspection. Pharmacy notification of medication incidents was removed. The concerns and the non-compliance with the Act and Regulations related to medication incidents at the home were not addressed. The revised policy and medication incident protocol had not been reviewed by the Pharmacist.

The licensee has failed to ensure that every medication incident that involved a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health. All medication incidents were not documented, reviewed and analyzed; corrective action was not taken as necessary; and a written record was not kept of everything as required.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that two identified resident’s care was provided to the residents as specified in their plan of care.

A) Multiple complaints were received by the MLTC related to a medication incident that occurred on a specific date. The complainants stated that the resident missed a scheduled intervention because the medication pass had not been completed as scheduled.

The plan of care for the identified resident stated they were at risk related to a specific diagnoses. The resident was dependent on staff for their care. Registered staff were required to provide the resident a specific intervention at specific times. The home's dated reports showed that the intervention was not provided to the resident on a specific date as required.

A registered staff member said that directions for the the resident's intervention were found in the resident's plan of care. A registered staff member confirmed that on a specific date the resident’s intervention had not been provided as ordered.

B) The licensee has failed to ensure that an identified resident’s specific intervention was provided to them as specified in their plan of care.

The plan of care for the resident stated the intervention and the directions for the registered staff. The resident was at risk related to a specific symptom. A registered staff member said that the resident's intervention was found in their plan of care and was a registered nurse’s responsibility.

The home’s record showed that on a specific date the intervention was not provided and documented until over two hours later. A registered staff member confirmed that the resident's plan of care should have been followed and was not.

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee failed to ensure that where the Regulation required the licensee to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 114 (2), the licensee was required to ensure that written policies and protocols were developed for the medication management system to ensure the accurate dispensing and administration of all drugs used in the home.

Specifically, staff did not comply with the licensee’s dated narcotics and controlled medications policy, which was part of the licensee’s medication management program.

The home's policy was provided to inspectors by a registered staff member and the DORPC. They said that this was the current policy used in relation to the home's narcotic and controlled substance medication count. The policy included the process registered staff were to follow.

i) On a specific date, a RN did not administer an identified resident's scheduled narcotic medication at a specified time. They worked a partial shift and did not complete a narcotic count. The on-coming registered staff was not aware that all morning controlled substance medications had not been administered. The Narcotic and Controlled Drug Administration records for two residents did not document that the count of their controlled substances was completed at registered staff shift change that took place at a specific time.

ii) On a specific date, the same RN worked a partial shift. No narcotic count was completed at a specified time. Several controlled substance medications had not been administered at the specified and had to be given late by the on-coming registered staff member. The Narcotic and Controlled Drug Administration records for three residents did not document that the count of their controlled substances was completed at registered staff shift change that took place at a specific time.

iii) On a specific date, the same RN worked a partial shift. No narcotic count was completed at a specified time. The Narcotic and Controlled Drug Administration records for two residents showed that a narcotic count was not documented as completed at a specific time.

The home’s policy documented that the registered staff arriving on duty and the registered staff leaving were to complete the count together. Three registered staff members confirmed that this did not always occur. They described the shift change process and stated that once specific medication administration tasks had been completed they were responsible for the medication administration to the residents. They stated that they would complete a narcotic count even for a partial shift.

The ADOC stated that two registered staff should count the narcotics and controlled substances, one staff looked at the medication cards and one staff signed the medication sheet and it was important to do the count to identify discrepancies and address them immediately.

The home's records showed that the RN failed to comply with the home's dated narcotics and controlled medications policy which directed the registered staff to complete a narcotic and controlled substance count with the out-going registered staff, who had previous responsibility for the medication administration to the residents, together with the on-going registered staff who then assumed responsibility for the medication administration on the unit.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's narcotics and controlled medications policy is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a person who had reasonable grounds to suspect that sexual abuse had occurred reported this suspicion to the Director immediately as required.

A complaint was submitted to the MLTC which reported that an identified resident had exhibited inappropriate behaviours towards another resident. The incidents of alleged abuse were not reported to the Director by the home.

A search of MLTC critical incident (CI) report submissions related to alleged abuse for a specific period showed that there were no CI's submitted by the home related to either identified resident. The DORPC agreed that they were aware of the incidents and a CI should have been submitted to the Director and was not.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that abuse had occurred or may have occurred immediately reported the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

The licensee has failed to ensure that interventions were identified and implemented to minimize the risk of altercations and potentially harmful interactions by an identified resident towards another identified resident.

A complaint was submitted to the MLTC which stated that a resident had exhibited inappropriate behaviours towards another resident.

The resident’s plan of care identified three incidents of inappropriate behaviours towards a specific resident that had occurred on specific dates. The records showed a history and pattern of potentially harmful interactions that had continued to occur.

Two Behavioul Support Ontario (BSO) staff both stated that likes, dislikes, triggers, and interventions for each resident on the BSO caseload were found in BSO binders on each unit. The identified resident also had their own binder. A BSO staff stated that the written strategies and approaches to respond to or minimize the resident’s behaviours were also found in their plan of care.

The resident's care plan showed that a specific intervention was not initiated until after two incidents had occurred. No specific interventions to manage the resident’s inappropriate behaviours were documented in the resident's plan of care. A RPN stated that the resident's inappropriate behaviours were not listed in the binders.

The BSO Lead stated that interventions in place for the resident had not been effective because incidents continued to occur. They explained that these incidents may have been prevented if specific interventions had been implemented when a pattern was first established.

The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between two identified residents which included identifying and implementing interventions for a resident related to their sexual behaviours.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

WN #7: 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 :

The licensee has failed to ensure that an identified resident's medications remained in the original labelled package provided by the pharmacy service provider or the Government of Ontario until administered to the resident. A prescribed narcotic was not destroyed.

The resident's plan of care documented specific medications and their schedule. The home's specific dated reports showed that the RN had found the resident's medications, which included a controlled narcotic, pre-poured by another RN. The RN stated they had administered these medications to the resident.

Another RN said that the resident had initially refused these medications when they had prepared them at a specific time. The RN said they had intended to re-approach the resident but forgot.

The home's specific dated records were inconsistent in the quantity and administration time related to the resident's narcotic. The records showed that the resident's medications were given by the RN who had not prepared and dispensed the medications from the original packaging.

The DORPC stated that the expectation was that a late medication, which was close to the next dose, was documented as missed and wasted. They also said the doctor should have been involved with this decision. The records showed that this did not occur.

On a specific date, a RN failed to ensure that an identified resident's scheduled medications were administered from the original packaging. In addition, a prescribed narcotic was not wasted and not re-dispensed to the resident as required.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance 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, to be implemented voluntarily.

WN #8: 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 :

Compliance order (CO) #001 from inspection 2019_739694_0013 was issued on August 6, 2019, and had a compliance due date (CDD) of August 15, 2019. The following is further evidence to support CO #001.

The licensee failed to ensure that an identified resident was protected from abuse by anyone.

A complaint was submitted to the MLTC which reported an allegation of abuse by an identified resident towards another resident.

The plan of care indicated that the identified resident had a mild cognitive impairment. The other resident had moderate to severe cognitive impairment and could not provide consent.

The identified resident's plan of care identified three dated incidents of inappropriate behaviour. Interventions to respond and prevent recurrence were not implemented in the resident's plan of care. The resident realized their behaviour had bordered on inappropriate.

The BSO Lead stated that interventions in place for the resident had not been effective because the incidents continued to occur. Four staff all stated that they considered the incidents to be inappropriate. Two staff said that the resident could not provide consent.

The licensee failed to ensure that an identified resident was protected from abuse by another resident on specific dates.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

The licensee has failed to ensure that access to areas where drugs were stored were restricted to persons who may dispense drugs in the home.

On a specific date, the keys to the medication cart and medication room were given to a Personal Support Worker (PSW). The PSW confirmed that they had the keys for a period of time. Registered staff confirmed that the expectation was that the keys to the medication cart and room were held by registered staff who administered the resident's medications.

The licensee has failed to ensure that access to areas where medications were stored were restricted to the registered staff who dispensed and administered the resident's medications in the home.

Issued on this 6th day of November, 2019

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

Ministère 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) :	SHERRI COOK (633), KRISTAL PITTER (735), VALERIE GOLDRUP (539)
Inspection No. / No de l'inspection :	2019_610633_0014
Log No. / No de registre :	013729-19, 013730-19, 014635-19, 014892-19, 015888-19, 017181-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 18, 2019
Licensee / Titulaire de permis :	Saint Luke's Place 1624 Franklin Blvd., CAMBRIDGE, ON, N3C-3P4
LTC Home / Foyer de SLD :	Saint Luke's Place 1624 Franklin Boulevard, CAMBRIDGE, ON, N3C-3P4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Maureen Toth

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Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

To Saint Luke's Place, 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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 131 (2).

Specifically, the licensee must ensure:

1) That all residents that reside on two specific resident home areas (RHA) are administered their medications in accordance with the directions for use specified by the prescriber.

2) That the ADOC reviews the College of Nurses of Ontario (CNO) practice standards "Medication 2019" and "Documentation 2019" and completes the learning modules 'Medication" and "Documentation" available at http://www.cno.org/en/learn-about-standards-guidelines/educational-tools/learning-modules/professional-standards/. The RN completes the CNO online participation form and a record is kept at the home.

3) That an auditing process is developed and fully implemented that monitors medication administration at the home. The auditing process must be documented and include who is responsible to complete the audit, the resident home areas, the frequency, the date and results of the audit, and the date of corrective action and/or changes that were identified and implemented, if any.

Grounds / Motifs :

1. On three specified dates, a number of residents did not receive their medications in accordance with the directions for use specified by the prescriber.

A) Multiple complaints were received by the Ministry of Long-Term Care (MLTC)

related to a medication incident that occurred on a specific date and time.

The home's records showed that a number of residents did not receive any of their medications on a specific date and time. A number of other residents did not receive their scheduled medications until up to two hours after the prescribed time. The accountable RN had not completed the medication pass. The missed medications were for specific diagnoses and symptom management.

Residents interviewed were unable to recall this incident related to their level of impaired cognition.

The plan of care for all identified residents and the home's dated reports showed the medications were missed and the impact on three specific residents.

Specific medication administration tasks were completed at identified times. Several registered staff stated that once these tasks had been completed the on-coming registered staff member was responsible for medication administration to the residents.

On a specific date, a number of residents did not receive their medications as prescribed. This was related to a scheduled medication pass which had not been completed by the RN.

B) A second medication incident was identified which occurred on a specific date. Multiple residents did not receive their scheduled medications within one-hour of the prescribed time. The same accountable RN had initiated the medication pass however, they did not complete the pass and multiple medications had to be given by the on-coming registered staff member.

The home's dated records showed that a number of residents did not receive their scheduled medications until two and three hours from the prescribed time. The missed medications were for specific diagnoses and symptom management.

The residents interviewed were unable to recall this incident.

The plan of care for all identified residents and the home's dated reports showed

the medications were missed and the impact on three specific residents.

On an identified date, a number of residents did not receive their medications as prescribed. This was related to a scheduled medication pass that had not been completed by the same RN.

C) A third medication incident occurred on a specific date, which involved the same RN. An identified resident did not receive a specific medication as prescribed.

The home's records related to this incident were inconsistent and incomplete. An assessment was not documented, the medical doctor (MD) was not contacted and there was no MD order obtained.

Multiple registered staff, the Associate Director of Care (ADOC) and the Director of Resident and Personal Care (DORPC) confirmed that the expectation was that medications were to be given as directed by the order and within an hour of the prescribed time. The two identified medication passes should have been completed by a specific time and were not. The DORPC acknowledged that a medication pass may have impact on the on-coming registered staff member and the resident's next scheduled dose. The DORPC confirmed that a doctor should have been contacted and directions and/or orders obtained in a situation where a medication was late and it was close to the next prescribed time. Nurses were expected to follow the standards of the College of Nurses of Ontario (CNO).

On three specific dates, the home's records showed that a number of residents did not receive their medications as prescribed by the same accountable RN.

The severity of the issue was a level 2, potential risk and the scope of the issue was a level 3, widespread. The home had a compliance history of 2, multiple unrelated non-compliance.

(633)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 29, 2019

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

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 135 (1)(2).

Specifically, the licensee must ensure:

1) That a thorough investigation is completed related to three medication incidents that occurred on specific dates. The home's investigation must be documented and include the person(s) who completed the review.

-That a written action plan is fully developed and implemented in consultation with the Professional Advisory Committee (PAC) based on the home's investigation. The plan must be documented and include the date, who attended, the identified action items from the home's investigation, strategies to address all non-compliance related to medication administration and incident reporting and the home's related policies contained in this report; who is responsible for the action items, and the date of implementation.

2) That the on-line Medication Incident Reporting System (MIRS) available through MediSystems is fully implemented. All documentation on the medication incident report is completed according to all requirements in the Act and Regulations, the home's revised policy and best practices.

3) That in consultation with PAC, which must include the Pharmacist, that the home's "Medication Incident" policy is reviewed and revised in accordance with requirements of the Act and Regulations and evidenced-based practices and complied with.

4) That all registered staff and Management receive training on the MIRS and the home's revised "Medication Incident" policy. A record of the training is kept in the home including the date, content and staff sign off.

5) That the ADOC and DORPC review the College of Nurses of Ontario (CNO) practice standards and complete the learning modules "Ethics", "Professional Standards" and "Code of Conduct" available at https://www.cno.org/en/learn-about-standards-guidelines/standards-and-guidelines/. The RNs complete the CNO online participation form and a record is kept in the home.

Grounds / Motifs :

1. The licensee has failed to ensure that every medication incident was documented together with a record of the immediate actions taken to assess and maintain the resident's health.

On three specific dates, a number of residents did not receive their scheduled medications as prescribed.

The plan of care for all identified residents and the home's records did not document an assessment of the residents and the actions taken.

Multiple registered staff said that in response to a medication incident, the resident should be checked, and they would document this. The ADOC said that the home's medication incident reports included a box to document the actions taken and they and/or the DORPC reviewed the reports for completeness, however, specific dated reports did not include an assessment of the resident and the immediate actions taken that were documented together as required.

2. The identified resident's plan of care and the home's dated records showed that three specific medication incidents, which involved a number of residents, were not correctly analyzed and documented. Corrective action was not taken as necessary. The records also showed that the residents' SDM and MD were not always notified.

Documentation on the home's medication incident reports and a specific related report was incomplete, inaccurate and not timely related to two medication incidents. There was no follow up documentation by the DORPC. Another medication incident was not self reported, and not reported by staff. The DORPC acknowledged that a situation where multiple residents did not receive their medication as ordered would be considered a medication incident and the home's process should have been followed in response. The home's records showed that this did not occur.

The ADOC and DORPC said that in response to a medication incident the SDM and MD were notified. An investigation and staff reflections were completed and staff counseling and education was provided. The home's records showed that there was no investigation and no corrective action taken related to three specific medication incidents.

The home's records showed that the same RN was accountable for medication passes on two dates and a medication incident on another date, however, a specific report did not include their medication errors. No strategies or trends were identified to prevent recurrence.

The home's policy related to medication incidents and near misses was not followed.

Multiple registered staff, the Team Lead for MediSystem Pharmacy, the Pharmacist, the ADOC and DORPC confirmed that the home's medication incident process was inconsistent, inaccurate and documentation was incomplete.The home's policy and process related to medication incidents lacked transparency.

The DORPC stated that the expectation for registered nurses was that they practiced in accordance with the CNO and the home's policies and standards.

3. O. Reg. 79/10 s. 120(3) states that the home's pharmacy service provider is required to participate in risk management and quality improvement activities which included the review of medication incidents.

The home's quarterly medication incidents for a specific period showed that all medication incidents, which included both nursing and pharmacy related errors, were not sent to the pharmacy by the home. The home's policy related to medication incidents and near misses was not followed. The registered staff said they did not have access to the on-line Medication Incident Reporting System (MIRS) to report the incidents themselves.

A specific report was based on inconsistent and incomplete medication incident documentation and a lack of analysis. The Pharmacist said they were not involved in the preparation and analysis of the home's quarterly medication incidents.

The MediSystems Team Lead and the Pharmacist both said the online MIRS was available to the home. The tool was comprehensive however, not in use. They confirmed the process and content related to a medication incident and the

home's records showed that this did not occur.

The licensee has failed to ensure that the pharmacy service provider participated in risk management and quality improvement activities which included reviewing the home's medication incidents.

4. O Reg. 79/10 s. 144 (a)(b) states that the written policies and protocols for the home's medication management system, which included the policy and protocol related to medication incidents, are to be developed, implemented, evaluated and updated in accordance with evidence-based practices and reviewed by the Pharmacist.

The home's medication incident policy was revised at the time of inspection. Pharmacy notification of medication incidents was removed. The concerns and the non-compliance with the Act and Regulations related to medication incidents at the home were not addressed. The revised policy and medication incident protocol had not been reviewed by the Pharmacist.

The licensee has failed to ensure that every medication incident that involved a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health. All medication incidents were not documented, reviewed and analyzed; corrective action was not taken as necessary; and a written record was not kept of everything as required.

The severity of the issue was a level 2, potential risk and the scope of the issue was a level 3, widespread. The home had a compliance history of 2, multiple unrelated non-compliance. (633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 13, 2019

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

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 18th day of October, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Sherri Cook

Service Area Office / Bureau régional de services : Central West Service Area Office