Ontario

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

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
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Amended Public Report Cover Sheet (A2)

Amended Report Issue Date: July 12, 2023
Original Report Issue Date: May 2, 2023
Inspection Number: 2023-1011-0003 (A2)
Inspection Type: Complaint Follow up Critical Incident System
Licensee: 2629693 Ontario Inc.
Long Term Care Home and City: Sarsfield Colonial Home,Sarsfield

Amended By	**Inspector who Amended Digital Signature**
Manon Nighbor (755)	Manon Nighbor Digitally signed by Manon Nighbor Date: 2023.07.13 14:54:42 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Reflect that in Non-Compliance #007, Nutritional Care and Hydration Programs, the resident's number was corrected in the first paragraph, issued in the Licensee's report under inspection #2023-1011-0002, dated May 2, 2023.

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Lead Inspector Manon Nighbor (755)	**Additional Inspector(s)** Julienne NgoNloga (502)
Amended By Manon Nighbor (755)	**Inspector who Amended Digital Signature** Manon Nighbor Digitally signed by Manon Nighbor Date: 2023.07.13 14:55:41 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Reflect that in Non-Compliance #007, Nutritional Care and Hydration Programs, the resident's number was corrected in the first paragraph, issued in the Licensee's report under inspection #2023-1011-0002, dated May 2, 2023.

INSPECTION SUMMARY

The inspection occurred on the following date(s):
On site: January 27, February 1, 2, 6, 7, 8, 9, 13, 14, 15, 16, 17, 2023.
Off site: January 30, 31, February 3, 10, 22, 27, 28, March 1, 2, 3, 6, 8, 2023.

The following intake(s) were inspected:
•Intake: #00019078 - Follow-up order related to doors in the home.

•Intake: #00001066 - [CI: 0943-000005-22] Critical Incident System related to the water heating system.
•Intakes: #00014032, #00014392 - Complaints related to bill of rights, alleged staff to resident abuse, transferring and positioning.
•Intake: #00014353 - [CI: 0943-000009-22] Critical Incident System related to, staff to resident alleged abuse.
•Intakes: #00014388, #00018500- Complaints related to alleged staff to resident abuse.
•Intakes: #00015813, #00018500- Complaints related residents' care.
•Intake: #00020005 - Complaint related to medication management.
•Intakes: #00020074, #00021260 - Complaints related to alleged neglect.

NOTE: A Compliance Order related to FLTCA, 2021, s. 76 (1), (2)(a)(b), (3)(b) was identified in this inspection and has been issued in a concurrent inspection, #2023_1011_0002, dated May 2, 2023.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2022-1011-0001 related to O. Reg. 246/22, s. 12 (1) 4. inspected by Julienne Ngo Nloga. (502)

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

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Infection Prevention and Control
Whistle-blowing Protection and Retaliation
Prevention of Abuse and Neglect
Quality Improvement
Reporting and Complaints
Falls Prevention and Management

AMENDED INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

Rationale and Summary:
Inspector observed the utility room door a jar, there was a white cloth inserted between the door frame and the lock mechanism.

Considering staff members were in visible sight supervising residents and the bottles, observed on the floor in the utility room were not identified as hazardous, residents were at minimal risk.

The door was immediately closed, and the bottles of cleaning products were locked. During the course of the inspection all non-resident areas doors were found closed and locked.

Sources: Inspector's observations and interview with multiple staff members.
[755]

Date Remedy Implemented: February 9, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident.

1- Rationale and Summary:
A resident's plan of care directed staff to add moisture to the resident's meal related to a specified health condition.

Observation of the resident during breakfast meal service showed the resident coughing and clearing their throat after each spoon of an identified texture modified food.

A staff member indicated that the specified texture modified food had adequate texture and moisture at the beginning of the first sitting at meal. The resident ate at the second sitting which was approximately 45 minutes since the texture modified food was placed in the steam table, making the meal dry out. The staff member indicated that nursing staff should add jam, milk, butter, or water to moisten the texture modified food.

Two staff members stated that they did not know what moisture to add to the texture modified food as sauce and gravy were not suitable for that a specified meal.

Another staff member indicated that the information written on the plan of care was provided by Registered Dietitian (RD) and directed staff to add moisteners (such as margarine, sauce, gravy). The staff member stated that they will follow up with the Registered Dietitian (RD) to clarify what type of moisteners to add to each food items.

By not adding moisture to the texture modified food, the resident was at risk of choking during the meal.

2- Rationale and summary:
In 2023, a resident had a fall while being transferred by a staff member. The staff member stated that the resident's legs were stuck in the wheelchair.

Observation of the fall preventive interventions pictogram placed above the resident's bed showed that

the resident was at high-risk of fall, they required staff to add footrests when the wheelchair was in motion.

Two staff members stated that they were directed to place the footrests all the time when the resident was in their wheelchair and tilt the wheelchair to transfer the resident, but the resident sometimes self-propelled. It was not clear to the staff members when to place the footrests.

One staff member indicated that the resident's need of a wheelchair with footrest was reassessed by the Occupational Therapist (OT) and they made recommendation in 2021. The staff member indicated that the use of the wheelchair footrests in the resident's plan of care was not clarified and did not provide the same information as per the pictogram above the resident's bed.

Because the resident's plan of care was not clear to staff, the resident was transferred without footrests and the wheelchair was not tilted, which resulted in injury.

Sources: Observation, plan of care, pictogram and staff interviews.
[502]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that 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: 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.

Rationale and Summary:
A Critical Incident System was received, related to suspicion of staff to resident alleged abuse.

A staff member said that when the resident shared information regarding the alleged incident, they shared this with their colleagues.

Another staff member stated that when they became aware of the alleged incident, they were told to report it to the Director of Care. The staff member said they reported the incident the next day to a

Registered Nurse. The Director of Care was not in the home that week.

Another staff member stated that they first heard about the incident from colleagues and when the resident told them directly, they did not report it.

The Medical Director who is the attending physician said that they were only made aware of the incident a week after the resident had initially reported the incident.

The licensee's investigation was initiated the day after the resident reported the alleged incident and reported the alleged incident to the Director eight days after the resident initially reported the incident to staff members.

As such, the licensee did not immediately report the alleged abuse incident.

Sources: Critical Incident System, the home's investigation report and interviews with multiple staff members.
[755]

WRITTEN NOTIFICATION: Additional training — direct care staff

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (7) 1.

The licensee has failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in abuse recognition and prevention prior to performing their responsibilities and yearly thereafter.

Rationale and Summary:
The licensee's Zero Tolerance to Abuse and Neglect, procedure #3 states that: education in providing staff with coping mechanisms (eg STOP, Gentle Persuasion Approach) is imperative and should be provided upon hiring and yearly for direct care staff. The licensee's staff members' training is conducted through SURGE eLearning.

A staff member confirmed they had not received any abuse recognition and prevention training offered by the licensee's SURGE eLearning and said they were not aware, that SURGE learning was available to

them.

Three other staff members stated they had not completed any abuse recognition and prevention retraining in the last year.

The abuse recognition and prevention training records requested were not made available.

Failure to ensure that all staff members received their retraining on abuse recognition and prevention may have impacted the staff's awareness to prevent, identify and report suspicions or alleged abuse, placing residents at a greater risk of abuse.

Sources: Zero Tolerance to Abuse and Neglect Policy, interviews with multiple staff members.
[755]

WRITTEN NOTIFICATION: General requirements

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.

The licensee has failed to ensure that the following is complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation.

Specifically the licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Rationale and Summary:
During the inspection the licensee was not able to provide a program evaluation record for the Skin and Wound Care and the Fall Prevention programs.

Both programs' date of revision were date stamped in 2023.

The Administrator Consultant shared that they had not completed program evaluations since the COVID pandemic had started, in March 2020.

With the absence of the programs' evaluation documentation, it is difficult to verify the interdisciplinary team members involved in the evaluation, a summary of the changes and their implementations which may potentially impact the residents' wound care and fall prevention interventions.

Sources:
Skin and Wound Care, Fall Prevention Policies and Programs and interview with staff members.
[755]

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

1-Rationale and Summary:
In 2023, a resident had a fall from their wheelchair, while being transferred by a staff member. The staff member stated that the resident's legs were stuck in the wheelchair. The fall resulted in an injury.

Observation of the fall preventive interventions logo placed above the resident's bed showed that the resident was at high-risk of fall, they required that footrest be applied when the wheelchair was in motion.

A staff member indicated that on the day of incident they stopped, suddenly the resident fell, and they did not have time to react. The staff member indicated that the footrests were not applied to the wheelchair during the transfer.

The staff member who was assigned to the resident indicated that they had not applied the footrest after they transferred the resident to the wheelchair on the morning of the incident as the resident sometimes self-propelled.

By not applying the footrest during transfer, the resident sustained a fall with injury.

2- Rationale and Summary:
A resident had a fall in 2023, with injury. A staff member indicated that a first staff member placed the

resident's support device upside down on the wheelchair after cleaning it. A second staff member had not corrected the placement of the support device properly before transferring the resident to the wheelchair after care.

A staff member indicated that the resident's support device on their wheelchair, created an angle that prevented them from sliding down. The staff member stated that the resident was trying to shift their body weight as they were uncomfortable. They verified the resident's wheelchair after the fall, the support device was upside down, and this led to the resident falling out of the wheelchair.

As such, the support device placed upside down contributed to the resident a fall.

Sources: Fall incident report, Progress notes, Inspector's observation, interview with staff.
[502]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2)

The licensee has failed to comply with the policies and procedures related to a resident' s hydration that include the identification of any risks related to nutritional care and dietary services and hydration, the implementation of interventions to mitigate and manage those risks and must be complied with.

Specifically, staff did not comply with the policies "Nursing/Dietary Referral Form", and "Nutrition Care Planning" dated April 1, 2013, which were included in the licensee's Nutrition and Hydration Program.

1-Rationale and Summary:
The home's Nursing/Dietary Referral Form stated that if a resident is documented as eating or drinking poorly for food or fluid for three or more days, the Registered Nurse (RN)/Registered Practical Nurse (RPN) will have completed a Nursing/Dietary Referral Form. The form is given to the Nutrition Manager, who implements the change and leaves it for the dietitian.

A resident's nutrition assessment on admission showed that the resident's target daily fluid intake was 1100 mL which was meeting 85% of their hydration needs (1300 mL).

Over a 10 day period in 2023, the documentation showed the resident was not meeting their daily fluid

target.

The above resident fluid intake showed that the resident was not consistently meeting their targeted fluid intake goals. A day in 2023, the resident was transferred to the hospital with a specified condition.

A staff member indicated that they had not received a Nursing Referral Form when the resident's fluid intake decreased.

2- Rationale and summary:
The policy stated that reassessment of nutrition plan of care may be triggered by the need of a new approach or focus if the resident's current needs are not being met.

A resident who was identified at high nutritional risk, related to a medical condition that impacting their ability to swallow food. The resident continued to have poor oral intake at meals and snacks. During a 10-day period in 2023, the resident was not consistently meeting their targeted fluid and food intake goals.

A staff member indicated that they did not trigger a nutritional reassessment for the resident as the resident's Substitute Decision Maker (SDM) told them that the resident had an end stage disease. The staff member said they did not implement any immediate interventions since the resident was to be transferred to the hospital as per resident's advanced directives.

The non-compliance to the licensee's Nutrition and Hydration policy, contributed to the deterioration of the resident's health condition.

Sources: Policy, plan of care, food and fluid intake, staff interview.
[502]

WRITTEN NOTIFICATION: Menu planning

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (5)

The licensee has failed to ensure that an individualized menu was developed for a resident whose needs could not be met through the home's menu cycle.

Rationale and Summary:
A resident was assessed at high nutritional risk related to a specified medical condition and required 2000 kilocalories (kcal) daily.

In September 2022, the resident vomited undigested food for the first time and continued to have persisting emesis after meals. In November 2022, the resident told the physician that they were fed up with emesis all the time and they would be happy to have a specified treatment if it would prevent emesis.

In December 2022, the attending physician in hospital indicated that the resident's health condition had no effect on the resident's digestion and recommended that the resident eats frequent small meals and slowly.

Further review of the progress notes showed that the resident continued occasionally to have emesis and refused to eat or drink for two days in January 2023.

Observation during mealtimes and the resident's plan of care showed that the resident received half of the regular portions at meals to aid digestion related to frequent nausea and emesis which was less than their 2000 Kcal energy needs.

In November 2022, the Registered Dietitian (RD) assessed the resident and noted that identified symptoms of the resident's condition may have been increasing the energy expenditure, but the intake remained unchanged. They recommended to encourage the resident to continue to eat all three meals and three snacks and to continue to monitor the significant weight changes.

During that period, the resident had gradually lost weight to an undesirable significant weight loss of nine percent (9%) over three months and 4.7% over the last month.

Three staff members indicated that the resident required half portions of texture modified food at all meals and ate independently.

Another staff member indicated that the daily emesis started in October 2022, followed with the resident refusing meals regularly, which was reflected to the resident's weight lost. They had not changed the resident's dietary plan because the resident was referred to an identified specialist and they were waiting for the new treatment to work.

The staff member indicated if they had been made aware of the GI's recommendation of the frequent

small meals, they would have added nutritious meals for snack in the morning with the goal of prevention further weight loss.

By not implementing an individualized plan for the resident, the resident's nutritional needs were not met resulting in a significant weight loss of 9% over three months or 4.7% in a month.

Sources: observation, plan of care, hospital discharge report, staff interviews.
[502]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure implementation of any standard or protocol issued by the Director with respect to infection prevention and control.

Specifically under the Infection Prevention and Control (IPAC) Standard: 9.1 where the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. At a minimum, routine practices shall include: hand hygiene, including, but not limited to, the four moments of hand hygiene.

Rationale and Summary:
On five night shifts, five staff members had not performed hand hygiene as per minimum routine practices, infection prevention and control standards during the morning care provision to residents occupying four different bedrooms.

The failure to perform hand hygiene between residents' care placed residents at risk for infection.

Sources: Inspector's review of the home's video camera footage.
[755]

WRITTEN NOTIFICATION: Quarterly evaluation

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 124 (1)

The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Rationale and Summary:
The attending physician reviews the residents' quarterly drug regime with the residents' Physician Medication Reviews on their weekly visits. A gap between a resident's Physician Medication Reviews, was identified.

The attending physician stated that gaps between the Physician Medication Reviews were a common occurrence. The DOC stated that they were aware and concerned of the delay in the quarterly medication reviews.

The pharmacist indicated that since the change in process, the Medication Reviews were not as effectively being reviewed as with the previous process.

As such, the licensee's interdisciplinary team had not quarterly evaluated the effectiveness of the residents' medication management system, placing residents at risk with their administration and reactions to medications.

Sources: Resident's Physician Medication Reviews, interviews with multiple staff members.
[755]

WRITTEN NOTIFICATION: Administration of Drugs

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

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

Rational and Summary:
A treatment was prescribed four times weekly for a resident's altered skin integrity. The resident received their first dose 11 days after it was prescribed and the next dose, five days later.

The delay in the administration of the treatment prescribed, may have potentially affected the resident's altered skin integrity.

Sources: Physician Order Form, Medication Treatment Administration Records (eMARs), Medical and Nursing Administration Steps to Follow After Doctors Order Policy 6.9 and Interviews with staff members.
[755]

WRITTEN NOTIFICATION: Residents' drug regimes

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 146 (c)

The licensee has failed to ensure that, there is, at least quarterly, a documented reassessment of each resident's drug regime.

Rational and Summary:
The attending physician reviews the residents' quarterly drug regime with the residents' Physician Medication Reviews on their weekly visits.

A six-week gap was identified between a resident's two Physician Medication Reviews.

The attending physician stated that gaps between the Physician Medication Reviews were a common occurrence.

The Director of Care stated that they were aware and concerned of the delay in the quarterly medication reviews.

The pharmacist indicated that since the change in process, the reviews were not completed as effectively as prior to the change.

As such, the gap between the Physician Medication Reviews could potentially pose a risk to residents' health.

Sources: Resident's Physician Medication Reviews, interviews with multiple staff members.
[755]

WRITTEN NOTIFICATION: Medical Director

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 251 (1) 1.

The licensee has failed to enter into a written agreement with the Medical Director for the home that provides for at least the term of the agreement.

Rational and Summary:
The Medical Director indicated that they had repeatedly requested a contract renewal with the new licensee, who took ownership of the long-term care home as of the end of January 2020. The last signed contract they had was with the previous licensee.

The lack of collaboration with the Administration team related to home's Medication Management System, Medical Director and Attending Physician contracts, interdisciplinary communications were deciding factors in the Medical Director giving their resignation notification to the licensee.

The Medical Director/Attending Physician stated that they were in negotiations with the licensee related to the possibility of extending their stay as Medical Director/Attending Physician.

The Medical Director and Attending Physician contracts were made available 11 months after the indicated contract signature. The Administrator indicated in an email that they couldn't provide the contracts sooner since the Medical Director was away on vacation weeks before the contracts were made available.

As such, the licensee did not have a current Medical Director contract for their services available.

Sources: Communication with the licensee and interviews with attending Physician/Medical Director, Administrator and Consultant.
[755]

WRITTEN NOTIFICATION: Hiring staff, accepting volunteers

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 252 (1)

The licensee has failed to ensure that a vulnerable sector police record check is required before a licensee hires a staff member or accepts a volunteer as set out in subsection 81 (2) of the Act.

Rational and Summary:
It was confirmed that several staff members' vulnerable sector police checks were not available, in their employment files.

The home could not ensure that four staff members had passed a vulnerable sector police check prior to working in the home.

As such, not ensuring that all staff members had passed a vulnerable police safety check prior to working in the home may potentially have increased residents' risk of abuse.

Sources: Staff members' employment files and multiple staff interviews.
[755]

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 102 (4) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall ensure, that the interdisciplinary infection prevention and control team that includes the infection prevention and control lead, the Medical Director, the Director of Nursing and Personal Care and the Administrator co-ordinates and implements the program.

Specifically, the licensee shall:

A-Conduct an interdisciplinary meeting prior to June 5, 2023, which includes the IPAC Lead, the Medical Director, the Director of Nursing and Personal Care and the Administrator and schedule quarterly meetings thereafter.

B-Ensure the IPAC Lead(s) fulfills the required 17.5 hours per week in their role and keep a record of the hours for four consecutive weeks.

C-Ensure that all PPE is readily available to staff, at all times. And that staff members know where to obtain extra PPE within the home, as required.

D-Provide education to the IPAC Lead(s) and DOC which includes best practices according the legislative requirements, the home's local Public Health Unit's recommendations and the IPAC Ministry of Long-Term Care Standard.

E-Keep a record of all the steps indicated above, including A, B, C, D.

Grounds
The licensee has failed to ensure, that an interdisciplinary infection prevention and control team that includes the infection prevention and control lead, the Medical Director, the Director of Nursing and Personal Care and the Administrator co-ordinates and implements the program.

Rationale and Summary:
The IPAC Lead stated they were not aware of any IPAC program evaluation. The IPAC Lead was unsuccessful in contacting the Administrator. They stated they were concerned about:
• Staff members not being aware where to locate Personal Protection Equipment (PPE) within the home.
• Not meeting the minimal hours required for the IPAC Lead role due to other assigned duties in the home. The IPAC Lead resigned the next week, during a COVID outbreak.

The secondary IPAC Lead stated that they were not aware if the home had any infection prevention and control written program and depended on the IPAC Lead and the Director of Care (DOC) for guidance.

A staff member explained that staff members did not enter the bedroom of a resident's with a infectious health ailment to check on them because of a specific PPE was not readily available and they did not

know where to find them in the home.

As such, an interdisciplinary infection prevention and control team had not co-ordinated and implemented the infection prevention and control program, placing residents at potential increased risk related to infection.

Sources: Inspector's observations, policy binder, resident's health record and interviews with several staff members.
[755]

This order must be complied with by September 29, 2023

COMPLIANCE ORDER CO #002 Medication management system

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall evaluate and implement their medication management system by completing the following:

A- Re-evaluate the Diabetic protocol and the following three policies:
-Medical and Nursing Administration Steps to Follow After Doctors Orders 6.9 policy.
-eMARS/eTARS (Medication and Treatment Administration Electronic Records) policy.
-Quarterly Medication Review policy.

B-Include the Director of Nursing and Personal Care, the pharmacy service provider and the Medical Director in this evaluation.

C- Make the necessary changes to the written protocol and policies in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

D- Implement the updated written protocol and policies, which includes providing education to all staff involved in the medication management system and that the updated written protocol and policies are readily accessible to staff.

E- Keep a record of all the steps indicated above, including A, B, C, D.

Grounds
The licensee has failed to ensure that the written policies and protocols must be, developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

1-Rational and Summary:
The Director of Care (DOC) provided the following policies that were available to them:
· Medical and Nursing Administration Steps to Follow After Doctors Orders 6.9
Effective October 2009, Revised May 2010 and April 2013.
· eMARS/eTARS Medication Administration, Treatment Administration (electronic Medication Administration Records and electronic Treatment Administration Records) Policy.
Effective March 2013, Revised April 2013.
· Quarterly Medication Review
Effective September 2009, Revised May 2010 and April 2013.

When inspector inquired about the outdated policies, the Administrator, Administrator Consultant and the General Director indicated that their policies were transferred to an electronic software system before 2020, which had been hacked. No documentation of the policy software system hack incident or the following policies updates since 2013 were made available upon request.

As such, staff members not having access to updated policies and protocol resulted with inconsistent diabetic care approaches and placed residents at risk with potential effects from medication administration errors.

2-Rational and Summary:
The attending physician said that the diabetic protocol was not being followed.

The Director of Care (DOC) provided the inspector the diabetic protocol which contained the Diabetes Medical Intervention Orders. The Diabetes Medical Intervention Orders was also observed, posted on the wall near the medication cart in front of the nursing office, during the course of the inspection. The Diabetes Medical Intervention Orders stated to call the attending physician if the glucometer read less than 3mg/L and greater than 15mg/L.

A resident‘s glycemic test results were 16mg/L and 20mg/L. There was no documentation recorded in the resident’s health record, that the physician was contacted and there was no record of any new

orders. The Medical Director said that they did not receive any calls related to hyperglycemia.

A staff member stated that they would call the doctor if the glycemic test results are greater than 20mg/L or less than five. Another staff member stated they would call the physician if the resident had a result greater than 15mg/L and the resident was symptomatic and greater than 20mg/L, asymptomatic. A third staff member stated they were not familiar with the diabetic protocol and were not aware of any glycemic parameters to call the physician.

The DOC stated that with glycemic test results of less than four and greater than 15mg/L, the interventions included documenting in the resident's health record and the expectation was to call the physician if greater than 20mg/L. They explained that the diabetic protocol they had provided the inspector with the parameter of greater than 15mg/L, was with their previous pharmacy provider. The current pharmacy provider has been providing services for the licensee for the past two years and the DOC provided the Diabetic Protocol Blood Glucose Monitoring Policy.

As such, there was potential risk for the resident's health with the inconsistent implementation of the diabetic protocol and the lack of integrated diabetic care.

3-Rational and Summary:
A resident had a wound. The Medical Director, prescribed a treatment four times weekly. The order was not co-signed by any nurses as per the licensee's Medical and Nursing Administration Steps to Follow After Doctors Order Policy 6.9.

The order was transcribed on to the next month's Medication Treatment Administration Record (eMAR), eMAR, the resident received their first dose several days later and the next dose was also administered multiple days later.

The resident's wound may have potentially been affected by receiving the treatment prescribed several days late.

Sources: Diabetes Medical Intervention Orders, Diabetic Protocol Blood Glucose Monitoring Policy, Medical and Nursing Administration Steps to Follow After Doctors Orders 6.9, eMARS/eTARS (Medication and Treatment Administration Records) Policy, Quarterly Medication Review policy, Physician Order Form, two resident's health care records and several staff members interviews.
[755]

This order must be complied with by September 29, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

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

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

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

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

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

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

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

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

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

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