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 420
Ottawa, ON, K1S 3J4
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Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: June 26, 2023
Original Report Issue Date: May 12, 2023
Inspection Number: 2023-1510-0003 (A1)
Inspection Type: Complaint Critical Incident System
Licensee: St. Patrick's Home of Ottawa Inc.
Long Term Care Home and City: St. Patrick's Home,Ottawa

Amended By	**Director who Amended Digital Signature**
Pamela Finnikin (720492)	Pamela Finnikin Digitally signed by Pamela Finnikin Date: 2023.06.29 11:04:19 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
This licensee inspection report has been revised to reflect removal of non-compliance FLTCA, 2021, s. 26 (1) (c), removal of two findings to O. Reg. 246/22, s. 108 (1) 3 and update to the compliance order due date. The inspection 2023-1510-0003 was completed on March 31, 2023.

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Long Term Care Home and City: St. Patrick's Home, Ottawa	
Lead Inspector Pamela Finnikin (720492)	**Additional Inspector(s)** Marko Punzalan (742406) Gurpreet Gill (705004) Laurie Marshall (742466)
Amended By Pamela Finnikin (720492)	**Inspector who Amended Digital Signature** Pamela Finnikin Digitally signed by Pamela Finnikin Date: 2023.06.29 11:04:41 -04'00'

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INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 24, 27-28, 2023 and March 1-3, 6-10, 13-16, 20-24, 27-31, 2023

The following intake(s) were inspected:
Medication administration intakes:
#00012992, CIR #3015-000101-22; #00014127, CIR #3015-000114-22 and #00015753 (complaint)
Alleged staff to resident abuse intakes:
#00013581, CIR #3015-000105-22 and #00015179, CIR #3015-000122-22
Alleged resident to resident abuse intakes:
#00013834, CIR #3015-000108-22; #00018561, CIR #3015-000003-23 and #00021185, CIR #3015-

000014-23
Alleged improper care/neglect of resident intakes:
#00013859, CIR #3015-000106-22 and #00019265, CIR #3015-000006-23
Fall of resident resulting in injury and a significant change in condition intakes:
#00014116, CIR #3015-000113-22; #00016913, CIR #3015-000124-22; #00018946, CIR #3015-000004-23; #00019971, CIR #3015-000009-23 and #00020387, CIR #3015-000011-23
Complaints related to resident care concerns intakes:
#00015670, #00021578, #00016263, #00017517, #00021488 and #00018312

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

Falls Prevention and Management
Infection Prevention and Control
Medication Management
Prevention of Abuse and Neglect
Reporting and Complaints
Resident Care and Support Services
Responsive Behaviours
Skin and Wound Prevention and Management

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.

The licensee failed to provide privacy for a resident during personal care.

Rationale and Summary

Review of video footage on a date in January 2023, showed a resident being transferred from the wheelchair to the commode using the sit-to-stand lift with three staff present. Once resident was transferred to commode, one staff member walked to the window to close the resident's curtain, after resident was sitting on the commode.

An interview with Restorative Aid (RA) confirmed that all resident's have the right to privacy during care. After review of the video footage, RA stated that curtains being opened during transfer and after

resident was on the commode did not respect the resident's right to privacy.

Sources: Video footage of a resident, interview with Restorative Aid.

[720492]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that the substitute decision-maker (SDM) was given the opportunity to fully participate in the implementation of a resident's plan of care.

Rationale and Summary

Review of progress notes indicated that urine collection was completed on a day in December 2022. No identified communication in progress notes from registered staff that SDM was contacted regarding urine collection, results of urine collection and initiation of medications to treat an infection.

The SDM reported that they were not notified of the infection until receiving a phone call from the home in January 2023, that the medication treatment was completed.

Review of physician orders indicated that on a day in December 2022, a telephone order was received to start the resident on a medication to treat an infection. The SDM was not notified as per the order sheet.

On a day in January 2023, progress notes indicated that the RN reported a conversation with the SDM regarding the infection and if it was resolved.

Assistant Vice President of nursing (AVP) confirmed that it was the responsibility of registered staff to contact the SDM regarding changes to the plan of care.

The risk was moderate, as failing to involve resident's SDM in the plan of care as required results in the SDM being unable to advocate for the resident and be notified of health status changes.

Sources: Progress notes, physician orders, interview with SDM and AVP.

[742466]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that the care set out in the plan of care was provided to residents as specified in the plan.

Rationale and Summary

#1
In November 2022, a telephone order was obtained by an RN for a doctor's order for a resident. This order was never collected.
The same order was requested again 18 days later and included vital sign assessment every shift for five days including temperature assessments.
Review of temperature assessments in December indicate that only three temperature checks were done over the five day monitoring period as ordered by the physician.
An RPN reported that all temperature checks are part of the assessment process for this type of doctor's order and are documented in point click care.

The licensee failed to ensure that the care set out in the plan of care was provided as evidenced by not completing the initial order and not completing temperature checks for five days as requested by the physician upon second order 18 days later.

The risk was moderate as there was a delay in treatment which could have impacted the resident's health.

Sources: Physicians Orders, temperature summary assessment, and interview with an RPN.

[742466]

#2
The plan of care indicated that a resident should be transferred with the assistance of two staff. On a day in February 2023, the progress notes recorded that the resident was assisted by one staff.

A PSW assisted the resident with toileting and was planning to ring the bell for assistance, but the resident suddenly stood up, fell, and sustained an injury as a result of the fall.

Restorative staff reported that the resident was required to be assisted by two staff with all mobility needs.

The licensee's failure to ensure that the plan of care was followed regarding two-person transfers for the resident resulted in the resident falling and sustaining an injury. This resulted in actual harm to the resident.

Sources: Plan of care, progress notes, interviews with PSW and Restorative staff.

[742406]

#3
The licensee failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan when the resident was not supervised during breakfast on a day in March 2023, as required.

The resident's plan of care included the interventions that the resident required supervision with eating and drinking, encouraged to eat one bite at a time, chew well, no talking while chewing, and finish coughing before continuing to eat or drink.

In March 2023, inspectors observed upon entry to the resident's unit, that they were sitting in the dining room and coughing while holding a glass of drink. The resident had food in front of them, and no staff were present in the dining room for seventeen minutes.

During interviews, a PSW and an RPN indicated that someone was supposed to supervise the resident, and an RPN stated that they are usually near the dining room to supervise residents.

As such, the lack of monitoring of residents may increase the risk of harm to residents.

Sources: The resident's health care records, interviews with RPNs and a PSW and observations made by inspectors.

[705004]

#4
A resident's clinical records showed that the resident was diagnosed with a medical condition requiring bowel management monitoring. The point of care (POC) documentation for this resident indicated that there was no documentation for the resident on six days in February and one day in March 2023.

The resident's short-term system management (STSM) indicated to give a medication to the resident for bowel management on day three.

Interviews with two RPN's indicated that they gave other medications to the resident but they did not give extra medication on day three.

The Vice President (VP) of nursing stated that the resident's physician indicated that the resident was supposed to receive this medication on day three, and the staff was supposed to administer it to the resident on day three as per the bowel protocol in the STSM.

Failure to follow the bowel protocol for the resident could increase the risk of complications to the resident.

Sources: The resident's health care records and interviews with the VP of nursing, and two RPN's.

[705004]

#5
Screen shot provided from video footage on a day in February 2023 showed staff member put a resident's feet into sit-to-stand lift without feet completely on the platform, without the resident's legs and knees straight and in position, and without the resident sitting up and centered in bed as per the resident's documented care plan.

The resident's plan of care dated January 2023 confirmed that the resident requires two to three staff for transfer using sit-to-stand lift and to ensure that the resident is sitting tall and centred, to position both feet completely on the platform and to make sure the resident's legs and knees are straight and in position.

Restorative Aid (RA) reviewed the screen shot in March 2023 and confirmed that staff should not transfer the resident or strap in their feet to the sit-to-stand lift without the resident sitting up and having both feet completely on the floor as per care plan and that the staff did not follow the care plan for the resident in February 2023.

Failure to follow the resident's care plan put them at a moderate safety risk as the resident requires extensive assistance with transferring.

Sources: Screen shot of video footage dated February 2023, the resident's care plan, and interview with

the RA.

[720492]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of the care set out in two resident's plan of cares were documented as required.

Rationale and Summary

#1
The point of care (POC) documentation for the resident showed that for the month of January 2023, there were five days, where the resident's food and fluids intake at breakfast, lunch and 1000 hours fluids were not documented, and four days where supper and snacks were not documented.

The Vice President (VP) of Nursing indicated that the resident received their food and fluids, but it was not documented in the POC.

Therefore, the provision of care set out in the resident's plan of care regarding food and fluid intake was not documented.

Sources: The resident's health care records and an interview with the VP of Nursing.

[705004]

#2
The plan of care for a resident dated in July 2022 stated that the resident should be repositioned every two hours, and this intervention frequency was updated to every 45 minutes in October 2022.

Review of the resident's record in point of care (POC) indicated that the resident should be repositioned every two hours from July 2022 to October 2022, and every 45 minutes for 20 days in October 2022.

Further review of the resident's health record in Point of Care (POC) confirmed that there were seven days in July, seventeen days in August, eight days in September and eight days in October that had

missing documentation for repositioning records for the day and/or evening shifts.

Interview with an RN confirmed that staff should be documenting all care in Point Click Care (POC).

The VP of nursing reported that staff should follow the plan of care and ensure that documentation is recorded in PCC.

By not documenting the care provided, staff would not be aware of when and what care was provided to the resident.

Sources: The resident's health care record, plan of care, interview with an RN, and interview with VP of nursing.

[742406]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary

In February 2023, an RN documented in a resident's chart a witnessed incident of alleged sexual abuse where one resident kissed another resident.

Critical Incident Report (CIR) #3015-000014-23 was submitted in February 2023 to the Director and stated that the incident of alleged sexual abuse occurred, but was not immediately reported to the Director.

In an interview with the Assistant VP of Nursing (AVP) on in March 2023, they confirmed that the Director was notified of the incident for the first time when the CIR was submitted on a day in February 2023.

Failure to make mandatory reports to the Director may increase risk of negative interactions between

residents.

Sources: The resident's progress notes, CIR #3015-000014-23, and interview with AVP.

[720492]

WRITTEN NOTIFICATION: Directives by Minister

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee failed to comply with the Minister's Directive: COVID-19 response measures for long-term care homes, effective August 30, 2022, when they did not complete daily temperature checks for all residents, as set out in the COVID-19 guidance document for long-term care homes in Ontario.

Rationale and Summary

In an interview with the IPAC Lead in March 2023, they indicated that daily temperature checks were included in the home's process for COVID-19 monitoring and that registered staff document this in Point Click Care (PCC).

In an interview with an RPN in March 2023, they confirmed that daily temperatures are to be taken for each resident daily by registered staff as part of the home's process for COVID-19 monitoring.

The temperature logs were reviewed by Inspector #720492 in PCC for multiple residents, and confirmed that residents did not have daily temperatures completed since February 14, 2023.

An RPN reviewed the temperature logs of multiple residents on PCC and confirmed that staff were not completing daily temperature checks as required.

The home's failure to ensure that staff were completing daily temperature checks prevents early identification of a potential disease outbreak and the detection and management of sick residents.

Sources: PCC record review, and interviews with IPAC Lead and other staff.

[720492]

WRITTEN NOTIFICATION: Plan of Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 29 (3) 5.

The licensee failed to complete an assessment of a resident's new responsive behaviours and behavioural triggers in the plan of care post incident on a day in January 2023.

Rationale and Summary

Review of the resident's progress notes in January 2023 incident confirmed resident demonstrating new responsive behaviours resulting in an injury of another resident.

Review of the resident's plan of care dated January 2023 failed to include responsive behaviours and behavioural triggers post incident on a day in January 2023. No updates were made to the resident's documented care plan until March 2023.

Interview with Vice President (VP) of nursing in March 2023 confirmed that the resident's documented care plan should have been updated with any new responsive behaviours for the resident post incident.

As a result of the resident's plan of care not being updated with new responsive behaviours and triggers, there is a moderate risk to other residents' safety when staff are not made aware of any incident of new responsive behaviours, triggers and interventions in place for a resident.

Sources: The resident's health records and plan of care including documented care plan, interview with VP of nursing, an RN and other staff.

[720492]

WRITTEN NOTIFICATION: Transferring and Positioning Techniques

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee failed to ensure that staff use safe transferring and positioning devices and techniques when assisting a resident.

Rationale and Summary

Video footage of the resident dated from November 2022 - February 2023, and screen shots of the

resident from a date in January 2023 - March 2023 were reviewed. There were multiple instances of unsafe or improper transfer and repositioning techniques; lifting resident from lying to sitting position using resident's neck and hands as the contact points, wheelchair being tilted during a transfer, resident being strapped to lift without feet on the floor or resident being able to support their weight independently sitting up, resident being left alone strapped to lift, resident being put on lift with only one staff member present or a second staff member present not trained or qualified to assist with a transfer and resident's head not being supported during transfers using a mechanical lift.

Restorative Aid reviewed all the same video footage and screen shots noted above in March 2023, and confirmed that all occurrences involving the resident were considered unsafe transferring and positioning techniques, and unsafe lifts without the proper use of head support.

Failure of the staff to maintain safe transferring technique as per LTCH training, leaving the resident unattended, incorrect repositioning of the resident's wheelchair during transfers, not using appropriate head support during mechanical lift transfers, and not providing two qualified team members to assist with mechanical lift transferring, placed resident #003 at a high risk of injury and posed multiple safety risks.

Sources: Review of video footage and screen shots of the resident, resident records and plan of care including documented care plan, interviews with Restorative Aid and other staff.

[720492]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)

The licensee has failed to ensure that the resident was immediately repositioned every two hours or more frequently as required.

Rationale and Summary

The Plan of Care indicated that the resident was identified as dependent for all activity and required total care, including repositioning every two hours or more if clinically indicated.

Progress notes confirmed that re-positioning interventions for the resident were started on a day in July 2022. The initial start date for repositioning and turning was supposed to be three days earlier on a day

in July 2022.

In October 2022, the skin and wound specialist recommended repositioning the resident every 45 minutes since the wound deteriorated from stage 2 to stage 4.

During an interview, two PSW's reported that the plan of care for repositioning the resident every 45 minutes was not followed as recommended by the skin and wound specialist in October 2022.

An interview with the Vice President (VP) of nursing confirmed that PSW staff were supposed to initiate repositioning immediately for the resident upon their Admission in July 2022. Furthermore, the VP of nursing indicated that the registered staff were to ensure that skin and wound care was immediately initiated for the resident.

Staff failed to ensure that immediate repositioning upon admission was provided to the resident resulted in actual harm to the resident.

Sources: Progress notes, resident admission assessments, interview with PSWs, an RN, and VP of nursing.

[742406]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)

The licensee failed to ensure that when the resident demonstrated responsive behaviours, actions were taken to respond to the needs of the resident including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Rationale and Summary

Review of the resident's progress notes of an incident occurring in January 2023 documented that the resident demonstrated new responsive behaviours resulting in an injury of another resident.

Review of the resident's chart confirmed that no assessments or reassessments were completed related to the incident occurring in January 2023.

Review of the resident's chart confirmed that resident's response to an intervention of 1:1 for thirteen days in January 2023 was not documented.

Interview with BSO PSW in March 2023 confirmed that any resident with a new responsive behaviour is seen by the BSO team and an assessment is completed to determine resident needs including reassessment and outcome of interventions. During an interview, the PSW confirmed that no referral was sent to BSO post incident in January 2023.

Interview with an RN confirmed that after the resident's incident of new responsive behaviours on in January 2023, the resident had no reassessment completed or documentation related to the outcome of the 1:1 intervention put in place in January 2023 for the resident.

Interview with Vice President (VP) of Nursing in March 2023 confirmed that a BSO referral and reassessment of resident needs and interventions are required when demonstrating new responsive behaviours and that in this resident's case, this was not completed as expected.

Failure to reassess the resident and document the resident's response to the intervention post incident in January 2023 put other residents' safety at risk as further triggers and behaviours may not be appropriately identified for the resident.

Sources: The resident's chart and health records, interview with VP of Nursing, BSO PSW and other staff.

[720492]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

In accordance with the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes (LTCH), April 2022, Additional Precautions requirement 10.4, the licensee is required to ensure that residents received support to perform hand hygiene prior to receiving meals and snacks.

Specifically, the licensee failed to ensure that staff participate in the hand hygiene program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard) issued by the Director.

Rationale and Summary

Hand hygiene for residents was not observed prior to the meal or snack being served on the following units and dates:
Carlow House on February 24 and 27, 2023
Kelkenny House on March 1, 2023
Donegal House on March 1, 2023
Cavan House on March 1, 2023

Interview with IPAC Lead in March 2023 confirmed that staff are trained and reminded to complete hand hygiene with residents before and after meals and snacks and that this is a requirement for IPAC in the LTCH.

Lack of hand hygiene for residents increases the risk of disease transmission among residents and staff.

Sources: Observations made by inspectors, interview with residents, IPAC Lead and other staff.

[720492]

WRITTEN NOTIFICATION: Notification re: Incidents

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (b)

The licensee has failed to ensure that the resident's substitute decision-maker (SDM) was notified within 12 hours upon the licensee becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

Rationale and Summary

Critical Incident Report (CIR) #3015-000014-23 related to alleged sexual abuse by a resident witnessed by a PSW was submitted on a day in February 2023 to the Director.

A review of the resident's progress notes confirm there was no documentation that the SDM had been notified three days after the incident occurred.

An RN confirmed in an interview in March 2023 that the SDM was notified in February 2023, three days after the incident occurred, and that this was documented in the resident's chart.

Failure to ensure that a resident's SDM was notified of an alleged abuse delayed the resident from being provided support by their SDM.

Sources: CIR #3015-000014-23, the resident's health records, and interview with an RN.

[720492]

WRITTEN NOTIFICATION: Police Notification

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 105

The licensee failed to ensure the appropriate police force was immediately notified of an alleged incident of resident to resident sexual abuse.

Rationale and Summary

In February 2023, a resident was witnessed by PSW kissing another resident. The police were not immediately notified of this alleged incident of sexual abuse.

The progress notes in Point Click Care (PCC) for the resident confirmed that they were contacted in February 2023, three days after the incident occurred.

The Assistant Vice President (AVP) of nursing confirmed this documentation was correct.

Failing to immediately notify the police of alleged incidents of abuse potentially delays an investigation into the incident.

Sources: CIS #3015-000014-23, resident's progress notes and interview with the AVP of nursing.

[720492]

(A1)
The following non-compliance(s) has been amended: NC #014

WRITTEN NOTIFICATION: Dealing with Complaints

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 3.

The licensee failed to respond to written complaints concerning the care of a resident as required.

Rationale and Summary

The LTCH received a letter of complaint that outlined care concerns of the resident on two consecutive days in May 2022.

The VP of Nursing sent a response letter to the complainant in May 2022.

When the response was reviewed, the home did not include the Ministry's toll-free telephone number for making complaints and did not include confirmation that the licensee would immediately forward the complaint to the Director.

In an interview in March 2023, the VP of Nursing confirmed that the emails received by complainant as formal complaint in May 2022 related to care concerns for the resident were responded to in May 2022, but did not contain all information as required.

Sources: Review of complaint and response letters and interviews with the VP of Nursing.

[720492]

WRITTEN NOTIFICATION: Administration of Drugs

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee failed to ensure that drugs were administered to two residents in accordance with the direction specified for by the physician.

Rationale and Summary

#1
In October 2022, a resident had a seizure, and remained in the home.
The resident had a seizure again on a day in October 2022 that resulted in hospitalization.

In October 2022, Physicians Progress notes report that resident had two (2) seizures that week and Substitute Decision Maker (SDM) had reported to physician that neurologist recommended that a medication be increased.

Review of Physician orders from October 2022 indicated that the medication was increased to twice daily. There were no orders to discontinue this medication.

Review of medication audit report indicates that registered staff discontinued this medication on a day in October 2022, as it was identified as a duplicate medication order.

Review of the homes internal investigation timeline indicated that the order for this medication was incorrectly discontinued by nursing.

Review of medication audit report indicates that pharmacy continued to dispense this medication.

Physician notes from November 2022, indicated that this medication was discontinued unintentionally since October 2022 and was uncertain if resident had an unintended gap in their medication treatment.

Progress notes regarding medication and medication incident report indicate that this medication was delivered but current E-MAR did not show this medication as a listed prescription in Point Click Care (PCC).

RPN #116 reported that they recalled that one of the medications for seizure disorder was discontinued by accident and that the medication continued to be delivered by pharmacy and they labelled it as discontinued as it was not presenting in medication list in PCC.

The risk was moderate as omission of this medication may have contributed to the resident's health deterioration.

Sources: Progress Notes, physician progress notes, physician orders, medication audit, homes internal investigation timeline, Interviews with an RPN, RN and VP of nursing.

[742466]

#2
In November 2022, resident returned to home for palliation post hospitalization.

Palliative Symptoms Medication Order Form indicated that resident had orders for a medication be given every two hours.
Review of the homes timeline investigation report indicated that medication orders had not been confirmed as orders were written at change of shift. An RN drew up the medication without reviewing

orders and relied on verbal information from an RPN to read and report the medication order.

Progress notes from November 2022, written by an RN, report that physician was notified when the medication error occurred and continued to monitor the resident and held further doses of this medication.

Progress notes from November 2022 indicate that the resident was given the medication in November 2022 and physician and SDM were notified of medication error.

An RN admitted to failing to review the order, did not review the medication label on the medication and miscalculated the dose as they did not wait for pharmacy to process the order prior to giving the medication.

VP of nursing reported that the RN made a dosage error, and that the RN was unfamiliar with dosing of this medication.

Sources: Progress notes, homes timeline investigation report, St Patrick's Home record of death, Office of the Coroner institutional patient death record, Interviews with RN and the VP of nursing.

[742466]

COMPLIANCE ORDER CO #001 Medication Management System

NC #001 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:

1. Conduct weekly medication audits for a single random resident from three units each week until the order compliance due date June 16, 2023.

2. Evaluate written policies and protocols related to medication reconciliation which includes medication verification and review process when additional medications are sent by pharmacy but not in medication system or when medication duplication has been identified in the current medication system.

3. To ensure that the written policies and protocols are consistent with evidence-based practices, and if

there are none, prevailing practices. At a minimum, the Director of Nursing, the Medical Director, the pharmacy service provider and at least one member of the registered nursing staff must be involved in the evaluation of the licensee's medication reconciliation processes.

4. If the licensee's written policies and protocols related to medication-reconciliation are updated as a result of the evaluation required under step (2), ensure that all registered nursing staff, and others involved in medication reconciliation receive education on the changes.

A written record must be kept of everything required under steps (1), (2), (3) and (4) of this compliance order, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

Rationale and Summary

In October 2022 a resident had a seizure, the substitute decision-maker (SDM) was notified and the resident remained in the home.

The resident had a seizure on another day in October 2022 that resulted in hospitalization.

In October 2022, Physicians Progress notes report that resident had two seizures that week and (SDM) had reported to the physician that the neurologist recommended that anti-seizure medication be increased.

Review of Physician orders from October 2022 indicated that the medication was increased to twice daily. There were no new orders to discontinue the medication.

The medication audit indicated that the registered nursing staff discontinued the other anti-seizure medication, in October 2022, as it was identified as a duplicate medication order.

Review of the Investigation Medication Timeline from the Homes internal investigation reported that:

• October 2022 order audit report indicated that the RN discontinued the wrong medication because both started with the same letter.

• Medications were checked by two registered staff on two different days in October 2022.

• November 2022 the homes investigation discovered that 12 RPN's did not report that the discontinued

medication was being received in the packs from pharmacy.

• Two RPN's were interviewed and were not aware of reporting medication discrepancies' to pharmacy. No medication incident reports regarding medication discrepancies were found.
• Orders were not checked and instead the medication was discarded.

• The Home's investigation included interviews with registered nursing staff who confirmed that the discontinued medication was in the medication packs sent from the pharmacy but not listed in the e-MAR.

• November 2022 the homes investigation determined that there were communication issues with Point click care (PCC) and KROLL pharmacy management solutions interface determining that if an RN processes an order, then pharmacy needs to be notified by the home as the medication transcription is not communicated between systems.

As per the homes medication audit report dated in November 2022, it was identified that there were extra medications for the resident. Registered staff reviewed the additional medication and identified that the medication was discontinued in Point click care (PCC) e-mar but was not discontinued in the medical orders.

An incident report was completed in November 2022 after discovery of the medication inadvertently being discontinued.

This medication was restarted in November 2022.

The homes internal investigation determined that the medication was inadvertently deleted from of a prompt window in PCC which notifies the nurse that there is a duplication in medication orders for same illness. Both medications for same illness started with the same letter.

An email communication from the Homes Medical Director in November 2022, reported that after review of the home's medication incidents, there was an increase in medication errors that involved unintended discontinuation.

As per the homes internal investigation, pharmacy was notified and initiated an investigation and it was identified that there was a discrepancy in the pharmacy order and the resident e-mar. It was then identified that the resident's order for medication had been deleted in one system and not in the pharmacy KROLL system. The resident's order for the medication had never been discontinued in the pharmacy system.

An RPN reported that they recalled that one of the medications for seizure disorder was discontinued by accident and that the medication continued to be delivered by pharmacy and they labelled it as discontinued as it was not presenting in the medication list in point click care (PCC).

A pharmacist reported that once orders had been entered into their pharmacy system called KROLL the order information is then uploaded into PCC where the nurse had the responsibility of entering the medication data specifics and if an error is made then pharmacy had to be contacted to correct error. The Pharmacist also reported that PCC does not alert the KROLL system if the medications have not been given or discontinued by registered staff in PCC.

VP of nursing reported that the medication discontinuation error was missed because the nurse who inputted the medication into PCC was rushed and both medications for the same illness start with the same letter. DOC reported that there was never an order to discontinue the medication and therefore it was never caught because the medication was discontinued in between medication quarterly checks.

The LTCH's failure to ensure that medications orders were implemented according to the homes policy resulted in medication discontinuation. The risk is moderate as after a period of the medication being incorrectly discontinued, the resident had a seizure which resulted in hospitalization.

Sources: Policy for Medication Reconciliation IX NSG G 22.00, Progress notes, physician orders, medication audit reports, medication incident report, LTCH's internal investigation, medical director email communication, interviews with an RPN, RNs, the Pharmacist, RAI Coordinator, and VP of nursing.

[742466]

This order must be complied with by July 7, 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.