Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 6, 2017	2017_591623_0017	016959-17	Complaint

Licensee/Titulaire de permis

Glen Hill Terrace Christian Homes Inc.
200 Glen Hill Drive South WHITBY ON L1N 9W2

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

Glen Hill Strathaven
264 King Street East Bowmanville ON L1C 1P9

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

SARAH GILLIS (623)

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): August 15, 16, 17, 18, 21, 22, 23, 2017

The following log was inspected:
Log#016959-17 - related to medication, resident care, allegation of abuse, residents rights.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Educator, Nurse Practitioner (NP), Social Services, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Pharmacy Consultant, Behavioural Support Nurse (BSO), residents and family members.

In addition, the inspector toured the home, observed staff to resident and resident to resident interactions, reviewed clinical health records, staff education records, program evaluations, the licensees internal investigation reports and complaints records, internal wait lists for room transfers, policies related to complaints and response, abuse and neglect, critical incident reporting, responsive behaviours, medication orders - sending and receiving, medication administration, and medication incident reporting, oxygen use, continence care and bowel management.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and compliment each other.

Resident #001 was admitted to the home on a specified date with specific medical conditions. Resident #001 was cognitively well. Resident #001 passed away four months after admission to the home.

Review of the most recent written plan of care was completed for resident #001 which identified specific goals and interventions related to mood and a specific medical condition.

Review of the physician's orders for resident #001 was completed and the following were identified:

On a specific date and time new orders were written by Nurse Practitioner (NP) #105, three specific medications were discontinued. New orders were written for two specific medications to be administered daily and one specific medication to be administered if required.

Review of the progress notes for resident #001 for a specified 12 week period, indicated the following:

On a specific date and time the Post Admission Care Conference notes indicated that resident #001 had received a specific treatment for several years before admission. The SDM indicated that they would prefer that changes not be made to the treatment and medications.

On a specific date and time, RPN #119 documented that resident #001 was discovered in distress. An assessment was completed and interventions were put in place by the RPN. Within one minute resident #001 was no longer in distress and symptoms had subsided. RPN #119 notified the RN supervisor.

On a specific date and time the Nurse Practitioner (NP) completed an assessment of resident #001 due to a recent incident that resulted in an injury. The NP also completed a review of current medications and ordered that changes be made after consulting with resident #001.

The following day RPN #108 documented that resident #001 was received in bed receiving a treatment that was not being administered as ordered. RPN attempted to adjust the treatment but was not successful.The RPN attempted interventions as identified in the plan of care but was also unsuccessful, the treatment was left as it was found.

The next shift, RPN #110 documented that resident #001 was comfortable and the RPN decreased the treatment to what the order had indicated.

On a specific date and time RPN #104 documented that the Pharmacy was called and a message was left on the answering machine indicating that RPN #104 could not locate the drug order page in the drug record book indicating that the medications had been ordered and received from the pharmacy for resident #001. The RPN requested that the pharmacy return the call.

On the same day, RPN #104 documented that resident #001 indicated that a piece of medical equipment was not working properly. RPN #104 assessed resident #001 and noted the equipment appeared to be working properly. A physical assessment of resident #001 was completed and the resident appeared stable. RPN #104 requested that RN #106 Supervisor also complete an assessment of the resident. Later that same day resident #001 experienced a near miss when he/she had difficulty transferring and required assistance.

On a specific date and time RN #106 documented that he/she spoke to resident #001 regarding the near miss. Health teaching was completed and implications were discussed with resident #001 by RN #106, if the outcome had been different. RN #106 instructed resident #001 to use the call bell and to keep it close to call for assistance if required. The RN discussed the use of a safety device and indicated staff may use it if the resident continued to not call for assistance. RN #106 informed RPN #107 Charge Nurse to notify the residents SDM.

On a specific date and time, RPN #107 indicated that he/she was informed regarding near miss that resident #001 had experienced. RN #106 also stated to RPN #107 that if resident continued to not ask for assistance when needed, then a safety device would be an option. The SDM was informed of this by RPN #107 and the SDM agreed with the plan of care.

On a specific date and time, RN #106 was called to resident #001's room, resident was in distress. The RN completed an assessment, attempted interventions and the decision was made to transfer the resident to hospital for emergent care. The SDM was notified of the transfer.

On a specific date and time, RPN #104 indicated that resident #001 rang the call bell and stated they were not feeling well. RPN #104 assessed Resident #001 as the resident appeared to be in distress. Day RN #106 supervisor was called to assess the resident and the decision was made to send resident #001 to the hospital for further assessment.

On a specific date and time, RPN #104 documented that resident #001 only received one medication before being transferred to hospital as the ambulance had arrived before the other medications could be administered. Ambulance personnel were also informed of this.

During an interview on a specific date and time, RPN #111 indicated that he/she worked on a specific date and time. RPN #111 saw there were new orders written for resident #001 on the day prior. Three medications had been discontinued therefore the RPN did not administer them to resident #001. The new medications had not been received from pharmacy on the specified date. The RPN #111 told resident #001 that the medications were not available and if he/she needed the PRN medication to let the RPN know. RPN #111 indicated that a call was placed to the pharmacy, to inquire about the medications not being available, the pharmacy indicated that they had received the order and that one

medication would be coming but they needed clarification from the Nurse Practitioner (NP) for the second medication. RPN #111 indicated that the NP was already gone for the day so he/she unable to clarify the order and he/she did not call the MD to clarify the order either. RPN #111 indicated that he/she did not document the call to the pharmacy. RPN #111 indicated that it was busy so he/she told RPN #108 to call the doctor and clarify the order.

On a specific date and time during an interview RPN #108 indicated that he/she did not contact the Physician or Nurse Practitioner to inform them the new medication was not available for resident #001 and the order for the second medication required clarification. The RPN indicated that he/she was notified by the Pharmacy on a specific date and time, that there was a problem with the medication order. RPN #108 indicated that he/she discussed it with RPN #110 to decide what to do. RPN #108 indicated that he/she did not notify the RN Supervisor about the new medications not being available. RPN #108 indicated that shift, he/she gave resident #001 the discontinued medications and did not seek direction from the Physician or Nurse Practitioner. The RPN #108 indicated that on that same date, resident #001 was receiving a specified treatment at a higher level than prescribed. The RPN decreased the treatment and attempted to reposition the resident. The RPN #108 received a phone call from the SDM to say that they were concerned about resident #001. When RPN #108 went to assess resident #001, distress was noted. The RPN #108 indicated that he/she increased the specified treatment to level not prescribed. RPN #108 indicated that he/she encouraged resident #001 to keep the specified treatment at the prescribed level. RPN #108 indicated that he/she advised resident #001 that there was PRN medications available if required. RPN #108 indicated he/she did not notify the RN Supervisor, the Physician or Nurse Practitioner that resident #001's assessed levels were low despite receiving the specified treatment.

On a specific date and time during an interview RPN#104 indicated that he/she was working on a specific date. RPN #104 discovered that there had been a change in medications for resident #001. The RPN #104 gave the resident some of the medications as ordered, but there was one medication missing. RPN #104 contacted the pharmacy to notify them that the medication had not been received. RPN #104 indicated that a message was left on the answering machine for the Pharmacy. RPN #104 indicated there was only one attempt made to contact the pharmacy, and at the end of the shift he/she realized that the pharmacy had not called back, so he/she let the Supervisor, RN #106 know.
RPN #104 indicated that he/she did not contact the Physician or NP to notify them that the medication was not available, because he/she was waiting on the Pharmacy to call

back. RPN #104 indicated that the report from the prior shift was that resident #001 had used a specified treatment at a higher rate than prescribed. When RPN #104 checked resident #001 the treatment was administered as ordered. RPN #104 indicated that he/she was asked to go see resident #001 because the resident felt that the specified treatment was not working. When RPN #104 checked the specified treatment, it was working properly and residents #001's assessment was stable. Reassurance was offered and RPN #104 requested that RN #106 speak to resident #001 about the concerns. RPN #104 indicated that the following day, at the start of shift there was no mention at report of anything unusual for resident #001. RPN indicated that he/she did not further inquire about the missing medication. That morning resident #001 had breakfast in his/her room which was not unusual. RPN #104 was called to resident #001's room and was informed that the resident was in distress. RPN #104 took resident #001's scheduled medications to the room when he/she went to assess and administered it when it was discovered resident #001 was in distress. RPN #104 then called for RN #106 as there was obvious distress and resident #001 needed to be assessed. 911 was called by RN #106, RPN #104 indicated that he/she did not administer the PRN medication at that time as there was no chance to give it, the ambulance was here quickly and they took over.

During an interview RN #106 indicated the following:
Resident #001 had a history of a specified diagnosis and used a specific treatment. On a specified date, RN #106 indicated that he/she received a call at a specific time from RPN #104 who reported that resident #001 had experienced a near miss. RN #106 indicated that he/she went to resident #001 and assess the situation. At the time resident #001 was coherent and not in distress. RN #106 indicated that a discussion was held with the resident about using the call bell to call for assistance. RN #106 indicated that at the end of the shift he/she instructed the evening RPN #107 to call the SDM for resident #001 and let them know that there was a near miss earlier in the day. The RN recalled receiving a phone call earlier in the day shift from RPN #104 indicating that resident #001 was concerned about his/her specific treatment. The RN #106 asked RPN #104 if resident #001 was in distress, but did not go see resident #001 at that time. RN #106 indicated that he/she was made aware of the change in medications for resident #001, on that same day as RPN #104 was not certain how to administer the medication. RN #106 indicated that RPN #104 did inform him/her that there was a second medication that had not been received from the pharmacy and the RN and RPN #104 both checked the medication cart to look for the medication. The medication was not located and RN #106 instructed RPN #104 to call the emergency pharmacy to find out where the medication was. RN #106 indicated that he/she did not follow up with RPN #104 to see if the medication had been received. RN #106 indicated that he/she was aware that there

were changes in resident #001's medications but did not know exactly what medications resident #001 had been on or what the new orders indicated. RN #106 indicated that he/she did not look at the chart for resident #001 to see what was ordered and at no time did he/she contact the Physician or NP, or instruct the RPN to do so regarding the medication not being available. On a specified date, RN indicated that he/she was called by RPN #104 who stated that resident #001's was in distress. The RN went to assess, resident #001 was in obvious distress. The RN indicated that he/she attempted interventions and then informed resident #001 that they were sending him/her to the emergency room and called 911.

On a specific date and time during an interview Nurse Practitioner (NP) #105 indicated that he/she wrote the orders for resident #001 on a specific date, to stop three specific medications, and to initiate two new medications daily, a specific medication was also ordered as PRN. The NP indicated that it was assumed that the medication would arrive that evening as the order was written before the 1500 hours cut off time. The NP was not made aware that the medications did not arrive in the home until the following evening or that only one of the medications actually arrived. The NP indicated that he/she first became aware of the problem of the medication not being available, six days after the order was written, and after the resident was already admitted to the hospital.

Staff and others involved in the different aspects of care for resident #001 failed to collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and compliment each other. As a result, medications were stopped before new medications were available, despite repeated complaints by resident #001 that he/she felt distressed, staff did not collaborate with the Physician, Nurse Practitioner or Pharmacy to alert them of the medications not being available and the change in condition of resident #001's health status which ultimately resulted in resident #001 experiencing distress, which required transfer to hospital. [s. 6. (4) (a)]

2. The licensee has failed to ensure that staff and others who provide direct care to the resident are kept aware of the contents of the plan of care and have convenient and immediate access to it.

Review of the written plan of care for resident #003, identified specific responsive behaviours and included goals and specific interventions. Communication was also identified for specified reasons, the plan of care included goals and specific interventions.

The specific identified responsive behaviours were initiated in the care plan on admission

14 months prior, and there were no identified changes to the interventions since that date.

Behaviour Assessment Tool (BATool) was completed on a specified date, for resident #003. This tool was not available for staff who care for resident #003 as this tool was kept in the BSO office as indicated by RPN #114. The assessment identified specific behaviours, triggers and interventions that were not included in the written plan of care that was accessible to the staff and others who provided direct care to resident #003.

On a specific date and time during an interview BSO RPN #114 indicated that when a resident has an increase in responsive behaviours, a BATool is created for the resident. The completed tool is usually placed in the BSO binder in the nursing station and staff are to look there or in the care plan binder on the unit for the information. The RPN indicated that the BATool for resident#003 was not in the BSO binder at the nursing station, but rather in the BSO office, to which the staff who provide care cannot access. RPN #114 indicated that he/she is responsible to update the plan of care in point click care (PCC) if a BATool is created. RPN#114 indicated he/she was not sure why this was not done for resident #003.

During an interview on a specific date and time, the DOC indicated that there is a BSO program in the home. The expectation is that the BSO lead RPN #114 will receive the referrals that are made by the staff on the units, and provide an assessment for the resident as required. The BSO lead will also complete assessments and facilitate referrals to an external consultation provider, as well as work with the support staff from the external consultation service provider who attends the home weekly. The DOC indicated that the homes expectation is that registered nurses on the unit will document behaviours as they occur and include interventions that are used and successful. The BSO lead will assist to create a plan of care including identifying triggers and interventions that are appropriate for the resident so that the staff on the unit will have resources to help manage behaviours when they occur. These resources are to be accessible to all staff and others who provide direct care to the resident.

The plan of care for resident #003 was not accessible to all staff and others who provide direct care to the resident related to identified responsive behaviours, identified triggers and interventions to assist staff to manage the responsive behaviours. [s. 6. (8)]

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. 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 :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is:

(b) complied with related to O. Reg 79/10, s.114 (2) Every licensee of a long-term care home shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

A review of the MediSystem Pharmacy Policies:
Ordering and Receiving Medication (last review date January 16, 2017)

New Prescriptions - Digital Pen Ordering
1. The Physician's Order Sheet is the primary means for placing all new medication orders to pharmacy.
2. Fill out header information using the digital pen including Home Name, Room Number, Resident Name, allergies, date of birth and health card.
3. Multiple orders may be written on the Physician's order sheet. Prescribers may give telephone orders to a nurse who writes the order onto a Physician Order Sheet and records the name of the prescriber who gave the order.

4. Nurse then signs and dates receipt of the telephone order and flags chart in order to obtain the prescriber's signature at next visit.
5. A copy of the Drug Record Book page will automatically print, if the nurse initials the Drug Record Book (DRB) box located on the right hand side of the form.
6. Use the DRB page to document order and receipt of medications. File in the DRB in chronological order in the "ordered" section. This will quickly identify medication orders that have not been received.

Receiving Medications for non eMAR homes (Glen Hill Strathaven is a non eMAR home)

3. Unpack and check medications sent against Drug Record Book for accuracy and completeness. Any discrepancy must be reported to the pharmacy immediately.
4. While the packing slip is not required once the medications are signed in, they can be placed in the completed section of the drug record book. (Alternatively, the packing list can be signed , and attached to the order sheet as long as all items are examined and have arrived, and then filed.)
5. Complete the Medication Reorder Sheet entry noting date received and signature in the nurses signature box next to each medication.

Emergency Pharmacy Services - After-Hours Service (last reviewed January 16, 2017)

After-Hours Service
The after-hours pharmacist will be available to answer telephone calls outside of pharmacy's regular business hours. The after-hours pharmacist can be called under the following circumstances:

1. A new and urgent medication order written when the pharmacy is closed, and the medication is not available in the Emergency Drug Box (if applicable).
OR
2. Staff have questions regarding medications.

Procedure for Contacting After Hours Service
1. If you are serviced by Toronto or Mississauga MediSystem, call the after-hours cellular number.
3. If the call has been redirected to voice mail, leave a message indicating your name, telephone number, extension and the name of facility from which you are calling.
4. If the call has been redirected to voice mail, the after-hours pharmacist will return your call as soon as possible. Please ensure that you have access to the resident's chart and

are available to speak with the pharmacist.
5. If your call has not been returned within 20 minutes, repeat step 1.

Related to complaint log #016959-17

Resident #001 was admitted to the home with specific diagnosis. Resident #001 was cognitively well.

Review of the clinical records for resident #001 for a specified time period indicated the following:

Resident #001 was to receive a specified treatment.
A medication order was written on a specific date and time by Nurse Practitioner #105 to discontinue three specific medications and to initiate two specific medications to be administered daily and one medication PRN for specific symptoms.

This order was signed as processed and faxed to pharmacy by RPN #111, the day after it was written by NP #105, was second checked and SDM notified on the same date during the following shift by RPN #108.

Review of the paper medication administration record (MAR) indicated that three specific medications were discontinued on the date the order was written. These medications were not signed as administered the following day by an identified shift RPN, but was signed as administered by RPN #108 on another identified shift, despite being discontinued.

The MAR also identified the two new medications;
A specified medication daily was to begin on a specific date. There was no signature to indicate the medication was administered on the day it was to be initiated, medication is signed as given the following two days.

A second specified medication that was to begin on a specific date and the medication records indicated that the medication was not available for three days.

Review of the progress notes for resident #001 was completed and the following was indicated:

On a specific date and time NP #105 completed a review of specific medications for

resident #001. Orders were written to stop three medications and to initiate two new medications routinely as well as a PRN medication for specified symptoms. The NP indicated that the changes were discussed with resident #001, and the resident agreed with the plan of care.

The following day RPN #108 received resident #001 in bed, the resident was experiencing specific symptoms and the PRN medication was not offered or administered.

Two days after the new medications were ordered RPN #104 documented that one of the new medications had not been received from the pharmacy. A call was placed to the emergency Pharmacy and a message left indicating that the medication had not been received and requested a call back to clarify.

During an interview on a specific date and time, RPN #111 indicated that he/she worked the day shift on a specific date. RPN #111 noticed that there were new orders for resident #001 and there was no signature on the physician order page to indicate that the orders were processed. RPN #111 indicated that he/she checked and the change in medication orders had already been written on the MAR. RPN #111 indicated that the three medications were all discontinued so they were not administered to resident #001. The new medications had not been received yet from pharmacy so RPN #111 told resident #001 that the medications were not available and if the resident required the PRN medication for specified symptoms, to let the RPN know.
RPN #111 indicated that he/she called the pharmacy on a specific date to inquire about the medications not being available, the pharmacy indicated that they had received the order and that one of the medications would be coming that day, but that they needed clarification from the NP for the second medication order. RPN #111 indicated that the NP was already gone for the day he/she was unable to clarify the order. RPN #111 indicated he/she did not call the MD to clarify the order. RPN #111 indicated that there was no documentation to indicate that he/she had spoken to the pharmacy. RPN indicated that he/she asked RPN #10, who was on the next shift, to call the physician and clarify the order.

On a specific date and time during a telephone interview with Inspector #623, RPN #108 indicated that he/she was working on the date the new orders were received. The RPN indicated that he/she was aware that there were new orders for resident #001 written by the NP, but did not process them. The RPN indicated that it would be an expectation that he/she should process the orders if they were left from the prior shift but he/she was

busy so instead it was passed on to the next shift to process the new orders. The RPN #108 indicated that on a specific date he/she received the medication delivery from Pharmacy and signed in the medications. There was no memo from the Pharmacy regarding clarification of the order for the specified medication for resident #001. RPN indicated that if there was a memo he/she would have followed up. RPN #108 indicated that he/she did recall receiving a call from the pharmacy indicating that they only had one medication available and they would not be sending both. The RPN indicated that he/she could not recall if pharmacy specified which medication was not available. The RPN indicated that the pharmacy did not ask for clarification of the orders, they just stated that they did not have the medication in stock. The RPN #108 indicated that he/she did not document this phone call from pharmacy and did not pass along the information to the next shift.
RPN #108 indicated that he/she did not contact the MD or NP to let them know that the medication was not available when he/she was notified by the pharmacy. The RPN indicated that he/she discussed it with RPN #110 to decide what they were supposed to do. RPN #108 indicated that he/she did not speak to the RN Supervisor about the missing medications. RPN #108 indicated that he/she gave resident #001 the three discontinued medications on a specified date without an order, because the new medication was not available. RPN #108 indicated that he/she informed the night RPN #110 that he/she was continuing with the old order until the two new medications came in. RPN #108 indicated that this was decided because the MAR indicated D/C when new medications come in, and RPN #108 did not check the order written in the chart by NP #105.

RPN #108 indicated that the SDM for resident #001 was informed about the details of the new order. The RPN indicated that the SDM was also informed that only one medication was received and not two, the other was coming when it was available, the SDM did not indicated that there were any concerns. RPN #108 indicated that resident #001 was advised that PRN medication was available for specific symptoms, but resident did not request it.

A written statement was received from RPN #112 on a specific date, indicating the following information:

RPN #112 indicated that he/she processed the orders for resident #001 that were written by the Nurse Practitioner two shifts earlier. The RPN indicated that the orders were written on the MAR but noted that the new medication had not been received yet from Pharmacy. The RPN indicated that when processing the orders he/she discontinued the

three medications but also included a notation to ensure that they would be given until the new medication arrived. RPN #112 indicated that the original order did not state that the three medications were to be continued until the new medication arrived, RPN #112 felt it was implied in the order and did not clarify this with the NP. RPN #112 indicated that when the report was given to RPN #111, the nurse was informed that the medication had not been received and follow up with the pharmacy would be required on the next shift. RPN #112 indicated that he/she did not sign off on the medication order sheet that the orders were processed because only part of the order was processed. RPN #112 indicated that RPN #111 was asked to clarify and complete the processing of the order. RPN #112 indicated that he/she was not working for the three days following the the date the orders were written, therefore was not able to follow up with the pharmacy. RPN #112 assumed that the new medication orders would be clarified on a specific date by the identified shift and that the medication would arrive in the home that day.

On a specific date and time during an interview RPN#104 indicated that he/she was working the shift that the initial orders were written by the NP but was not aware that NP #105 had made a medication change for resident #001. The new orders were written at the end of the shift. RPN #104 indicated that when he/she arrived at work two days later, it was discovered that there had been a change in medications for resident #001. RPN #104 gave the resident one of the new medications but the second medication was not available. RPN #104 called to the pharmacy to inform them that the specific medication had not been received. RPN #104 indicated that a message was left for the pharmacy to notify them that the medication was not in the home. RPN #104 indicated that only one call was placed to pharmacy. RPN indicated that at the end of the shift he/she realized that the pharmacy had not called back and he/she let the Supervisor know (RN #106). RPN #104 indicated that he/she did not contact the MD or NP to notify them that the medication was not available. RPN #104 indicated that he/she did not offer or give resident #001 the PRN medication at any time as it was felt that resident #001 did not require it.

On a specific date and time during an interview RN #106 indicated that he/she was made aware of a change in medications for resident #001, two days after the initial order was written, by RPN #104. RN #106 indicated that RPN #104 did inform the RN that there was a second new specific medication that had not been received from the pharmacy and RN #106 and RPN #104 both checked the medication cart to look for it. The medication was not located, therefore RN #106 instructed RPN #104 to call emergency pharmacy to get the medication. RN #106 indicated that he/she did not follow up with RPN #104 to see if the medication had been received. RN #106 indicated that he/she did

not look at the chart for resident #001 to see what was ordered and at no time did he/she contact the MD or NP, or instruct the RPN to do so regarding the medication not being available.

On a specific date and time during an interview Pharmacy Consultant (PC) #103 indicated that when an order is written with the ePen, once the pen is docked it will transmit to the pharmacy. The person docking the pen should be looking to see that the pen is transmitting. Specific to resident #001 an order was written on a specific date and time by the NP. When reviewing the orders transmitted in the portal there was no indication that the ePen transmitted the order to the pharmacy on that date. The portal indicated that the order was faxed eight hours later, and the order was faxed a second time 26 hours after the order was initially written. The ePen did not transmit the orders as identified in the system.
The first part of the order was processed by the pharmacy and one of the new medications was received the day after the initial order was written. The second medication was not received. PC #103 indicated it would be the expectation that the pharmacy would have followed up with the home if there were clarification questions regarding the order requiring a specific dose. It would also be the expectation that when the home did not receive the medications as ordered, they would follow up with the pharmacy. PC #103 indicated that when an order is written using the ePen, if the DRB box is checked a confirmation page is automatically printed to be used by the home for their drug record book. This page is kept as a record of the medications being ordered and can be used for follow-up if medications are missing. PC #103 indicated that the pharmacy sent a clarification request for the order four days following the initial order.

On a specific date and time during an interview NP #105 indicated that he/she wrote the orders for resident #001 on a specific date, to stop three specific medications and to give two new medications daily, as well as a specific medication PRN for specific symptoms. The NP indicated that he/she does not always watch to see if the orders are transmitted to the pharmacy when written with the ePen and could not recall if they did for resident #001 on that specific date. The NP indicated that it was assumed that the medication would arrive that evening as the order was written before the 1500 hours cut off time. NP #105 was not aware that the medications did not arrive in the home until the following evening and that only one of the medications had arrived. The NP indicated that he/she first became aware of the problem six days later, after the resident was already admitted to the hospital. The NP did not receive the fax from pharmacy that came four days after the initial orders were written, seeking clarification regarding a specific medication. NP #105 indicated that the change in the medications was a suggestion of the Pharmacy

Consultant in an effort to reduce the number of medications that resident #001 received and to streamline and reduce to one dose per day of each medication. NP indicated that this was explained to resident #001 and the resident was in agreement to trialing the new medications. NP #105 indicated that he/she would expect that the nursing staff would seek clarification and direction when medications are not received from pharmacy, especially when there is an order to stop other medications. The NP indicated that the order did not clearly indicate to not stop the three specific medications until the new medications had arrived.

The MediSystem Pharmacy Policy - Ordering and Receiving Medication, was not followed when the Nurse Practitioner failed to observe if the order was transmitted when the pen was docked. A Drug Record Book page was not printed for the person who was receiving the order to identify that the medications were not received.
The nurse receiving medications did not immediately notify pharmacy of the discrepancy when the medications did not arrive the day that they were ordered. The nursing staff did not follow the procedures for contacting the emergency pharmacy services as per the MediSystem Pharmacy Policy - Emergency Pharmacy Services - After Hours Services, by only making an initial phone call two days later, and not following up when they had not received a call back within 20 minutes as indicated in the policy. [s. 8. (1) (b)]

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 by ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with related to medications, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the actions taken to meet the needs of the resident with responsive behaviours include: assessment, reassessments, interventions and documentation of the resident's responses to the interventions related to resident #003.

Resident #003 was admitted to the home with specific diagnosis including cognitive impairment.

Review of the licensee's internal investigation indicated that on a specific date and time, nursing staff heard yelling coming from resident #003's room. When staff arrived at the room resident #003 was yelling "you have to get out" to resident #002 who also shares the room. Resident #003 had displayed a physical altercation towards resident #002. Nursing staff intervened and removed resident #003 from the room. Resident #003 continued to exhibit specific responsive behaviours. Staff were unable to calm resident down, the Physician was contacted and orders were received for a specific medication to be given immediately and to repeat in 30 minutes if required. The police were notified and they attended the home to speak to resident #003.

Review of the progress notes for resident #003 for a specific three month time period indicated the following;

1) In the first month, there were seven documented incidents of specific responsive behaviours towards roommates, other residents and staff. On a specified date, a referral was made by RN #115 to the Social Worker and the Nurse Practitioner (NP) regarding

the increase in responsive behaviours. There was no documentation to indicate that the Social Worker or NP responded to the referral.
2) In the second month, there were 19 documented incidents of specific responsive behaviours towards roommates, other residents and staff. On two occasions the police were called to assist with resident #003 and there was one transfer to the hospital for assessment. The NP consulted on a specific date, and ordered specific medications to address the increase in responsive behaviours. After the medication was initiated, resident #003's behaviours worsened, PRN medication was prescribed and other clinical tests were performed. One week later, resident #003 was transferred to hospital for assessment when he displayed specific responsive behaviours towards staff. A BSO referral was made at that time as well as a medication review by the NP. Medication changes were made as well as a referral to an external support service for consultation was also made.
3) In the third month there were 12 documented incidents of specific responsive behaviours towards roommates, other residents and staff, not easily redirected and required medication on nine occasions to help settle. The progress notes indicated resident #003 required redirection when behaviours occurred as an intervention.

Review of the written plan of care for resident #003, identified specific responsive behaviours and included goals and specific interventions. Communication was also identified for specified reasons, the plan of care included goals and specific interventions.

During an interview on a specific date and time, PSW #113 indicated that resident #002 and #003 used to share a room. When they shared a room, resident #003 would frequently display specific responsive behaviours towards resident #002. There was one incident that PSW #113 was aware of, when resident #003 displayed a specific responsive behaviour towards resident #002. PSW indicated that resident #002 will engage in a verbal altercation with resident #003 if given the opportunity, but resident #002 had never been physical towards resident #003. PSW indicated that staff just know to keep these two residents separated.

On a specific date and time during an interview RPN #116 indicated that since resident #002 was moved, there had been no more incidents with resident #003. Resident #003 had adjusted to the new roommates. RPN indicated that resident #003 is unpredictable and staff need to visualize the residents whereabouts frequently throughout the shift. Resident #003 was on Dementia Observation System (DOS) monitoring for 14 days when new medication was started about one week after the specified incident with resident #002. The RPN indicated that before resident #002 and #003 were separated

with a room change, it was a daily occurrence for resident #003 to display specific responsive behaviours towards resident #002. The RPN indicated that other than separating the two residents, there were no other interventions put in place to prevent the behaviour. The RPN indicated there is a BSO-RPN in the home that is available for a resource. RPN #116 indicated that there was a referral made to an external resource for resident #003 but this was done after resident #003 had displayed specific responsive behaviours towards a staff member, and the RPN is not aware if the external resource had come to assess resident #003. RPN #116 indicated that the care plan was printed and available in a binder at the nursing station for each resident. The RPN indicated if there is an update to the care plan before the quarterly review is due then sometimes it is hand written in pen on the paper copy, but this is not always the case. The RPN indicated that he/she was not aware of a BSO binder that would have Behaviour Assessment Tool (BATool) in it to communicate information regarding behaviour triggers and interventions for specific residents.

RPN #114 indicated that he/she is the BSO lead for the home and follows resident #003. A referral was received when resident #003 displayed specific responsive behaviours towards resident #002. There are nine staff on the BSO team including the Nurse Educator, Social Worker, ADOC, two Activity Aides, three PSWs. RPN #114 indicated that resident #003 has had episodes of specific responsive behaviours involving resident #002 and was not aware of any other incidents of that nature involving other residents in the home. There have been many incidents where resident #003 had displayed other specific responsive behaviours towards other residents. On one occasion resident #003 had displayed a specific responsive behaviour towards the RN, as a result, a referral was made to an external resource for consultation, by the Nurse Practitioner (NP). RPN #114 indicated that when a resident has an increase in responsive behaviours, a BATool is created for the resident. It is usually placed in the BSO binder in the nursing station and staff are to look there or in the care plan binder on the unit for the information. RPN #114 indicated that he/she is responsible to update the care plan in PCC if a BATool is created.

RPN #114 indicated that staff are waiting for the recommendations from the external consultation before deciding the next steps for resident #003. The RPN indicated that the external resource had completed as assessment of resident #003 twice but no recommendations have been received. At this time there are no specific behaviour programs in place for resident #003. The RPN indicated that if there was an appropriate activity scheduled on the activation calender for the home then RPN #114 will refer the resident to it otherwise there really is not anything to provide distractions.

During an interview the DOC indicated that there is a BSO program in the home. The expectation is that the BSO lead RPN #114 will receive the referrals that are made by the staff on the units, and provide an assessment for the resident as required. The BSO lead will assist to create a plan of care including identifying triggers and interventions that are appropriate for the resident so that the staff on the unit will have resources to help manage behaviours when they occur. The BSO lead will also complete assessments and facilitate referrals to an external resource, as well as work with the support staff from that resource who attend the home weekly. The DOC indicated that the homes expectation is that registered nurses on the unit will document behaviours as they occur and include interventions that are used and are successful.

Resident #003 displayed ongoing incidents of specific identified responsive behaviours towards roommates, other residents and staff which included seven documented incidents in the first month, 19 documented incidents in the second month and 12 documented incidents in the third month. On a specific date, a referral was made by RN #115 to the social worker and the Nurse Practitioner (NP) regarding the increase in behaviours. There was no documentation to indicate that the Social Worker or NP responded to the referral until 19 days later, when the NP consulted and ordered specific medications to address the increase in responsive behaviours. On two occasions the police were called to assist with resident #003 and there was one transfer to the hospital for assessment, when resident #003 displayed specific responsive behaviours towards staff. A BSO referral was made at that time, as well as a medication review by the NP and a referral to an external resource for consultation. These referrals were not made until 52 days after the initial documented incidents of specific identified responsive behaviours had occurred. The actions taken did not meet the needs of resident #003 related to responsive behaviours; assessments, reassessments, interventions and documentation of the resident's responses to the interventions. [s. 53. (4) (c)]

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 by ensuring that behavioural triggers are identified and strategies are developed and implemented to respond to the behaviours, to be implemented voluntarily.

WN #4: 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 :

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

Review of the clinical records for resident #001 indicated that she was ordered to receive a specified treatment at a specific prescribed dose.

Review of the progress notes for resident #001 indicated the following;
On a specific date and time RPN #108 documented resident #001 had received a specific treatment at a dose that was not prescribed. A progress note written on a specific date and time indicated that RPN #110 documented at the beginning of the shift resident was discovered with receiving a specific treatment at a dose not prescribed.

During an interview RPN #108 indicated that on a specific date, resident #001 was receiving a specific treatment at a dose that was not prescribed. When RPN #108 assessed resident #001 and attempted to adjust the dose, resident #001 experienced a change in health status.

During an interview, RPN #111 indicated that she worked the day shift on a specific date.

RPN #111 did not recall dose of a specific treatment that resident #001 was receiving. RPN also did not recall resident #001 having any change in health status that day. RPN #111 indicated that on occasion resident #001 adjust the treatment dose and the RPN would change it back to the prescribed dose.

Review of the medication administration records for two specific months indicate that a specific prescribed treatment was not signed as administered on six specific occasions.

The licensee has failed to ensure that the specific prescribed treatment for resident #001 was administered as prescribed when RPN #108 documented that the treatment was administered to resident #001 a dose that was not prescribed, and by RPN #112 and RPN #111 failing to sign the MAR to indicate that the specific treatment was administered on six specific occasions.

An order was written on a specific date and time hours by Nurse Practitioner #105 that indicated the following;
- discontinue three specific medication.
- initiate two specific medications once daily and one specific medication PRN for specific symptoms.

Review of resident #001's MAR for a specific month, indicated that three specific medications were administered by RPN #108 after they were discontinued. Two new medication orders was not signed as administered by RPN #111 and the medications were not available in the home on a specific date. One new medication was signed for on two consecutive days as not available by RPN #104 with no follow up to indicate why.

During an interview RPN #108 indicated that on a specific date and time, he/she administered the three medications to resident #001 at two separate times. RPN indicated being aware that the medications had been discontinued and gave them without an order because the new medications had not arrived from pharmacy. RPN #108 indicated that he/she did not contact the MD or NP for direction when he/she was made aware that the new medications were not available.

During an interview RPN #111 indicated that on a specific date, he/she became aware that there had been a change in medications ordered for resident #001. RPN #111 indicated that three medications were discontinued so they were not administered to resident #001. The new medications were not yet received from pharmacy. RPN #111 told resident #001 that the medications were not available and if the resident needed the

PRN medication to let the RPN know. RPN #111 indicated that he/she did not contact the NP or Physician to notify them that the new medications were not available and to seek direction.

During an interview RPN #104 indicated that on a specific date, he/she discovered that there had been a change in medications for resident #001 two days prior. RPN #104 was only able to administer one of the new medications that were ordered. RPN #104 indicated that a call was placed to pharmacy to inform them the medication had not been received, but had to leave a message on the answering machine for the pharmacy. RPN #104 indicated that he/she only made the one call to pharmacy. RPN indicated that at the end of the shift he/she realized that the pharmacy had not called back and he/she let the Supervisor know (RN #106). RPN #104 indicated that he/she did not contact the Physician or NP to notify them that the medication was not available. RPN #104 indicated that he/she did not offer or give resident #001 the PRN medication at any time as the RPN did not feel it was required.

RPN #104, #111 and #108 failed to administer medications as prescribed to resident #001 on three specific dates. [s. 131. (2)]

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 by ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 8th day of November, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SARAH GILLIS (623)
Inspection No. / No de l'inspection :	2017_591623_0017
Log No. / No de registre :	016959-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 6, 2017
Licensee / Titulaire de permis :	Glen Hill Terrace Christian Homes Inc. 200 Glen Hill Drive South, WHITBY, ON, L1N-9W2
LTC Home / Foyer de SLD :	Glen Hill Strathaven 264 King Street East, Bowmanville, ON, L1C-1P9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michelle Stroud

To Glen Hill Terrace Christian Homes Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee is ordered to develop and implement a process to ensure that, when a resident's heath status is deteriorating quickly due to a condition causing acute distress, the assessments of all health care practitioners involved in the provision of care for that resident are seamlessly integrated and coordinated so that appropriate and effective interventions are implemented in a timely manner. This process shall include, but not be limited to, the following issues:

1. Ensure that the College of Nurses of Ontario Practice Standard - Professional Standards, Revised 2002, is understood by all registered nursing staff members, re-enforcing expectations re: Accountability for Registered Practical Nurses/Registered Nurses/Nurse Practitioner's when working in a multidisciplinary team.

2. Ensure that all registered nursing staff clearly understand their roles and responsibility regarding the processing, transcription, ordering of medications including medications ordered after-hours and on holidays/weekends. This will also include re-enforcing practice expectations related to collaboration with the pharmacist, Registered Nurses, Physician and Nurse Practitioner.

Grounds / Motifs :

1. 1. Resident #001 was admitted to the home on a specified date with specific medical conditions. Resident #001 was cognitively well. Resident #001 passed

away four months after admission to the home.

Review of the most recent written plan of care was completed for resident #001 which identified specific goals and interventions related to mood and a specific medical condition.

Review of the physician's orders for resident #001 was completed and the following were identified:

On a specific date and time new orders were written by Nurse Practitioner (NP) #105, three specific medications were discontinued. New orders were written for two specific medications to be administered daily and one specific medication to be administered if required.

Review of the progress notes for resident #001 for a specified 12 week period, indicated the following:

On a specific date and time the Post Admission Care Conference notes indicated that resident #001 had received a specific treatment for several years before admission. The SDM indicated that they would prefer that changes not be made to the treatment and medications.

On a specific date and time, RPN #119 documented that resident #001 was discovered in distress. An assessment was completed and interventions were put in place by the RPN. Within one minute resident #001 was no longer in distress and symptoms had subsided. RPN #119 notified the RN supervisor.

On a specific date and time the Nurse Practitioner (NP) completed an assessment of resident #001 due to a recent incident that resulted in an injury. The NP also completed a review of current medications and ordered that changes be made after consulting with resident #001.

The following day RPN #108 documented that resident #001 was received in bed receiving a treatment that was not being administered as ordered. RPN attempted to adjust the treatment but was not successful.The RPN attempted interventions as identified in the plan of care but was also unsuccessful, the treatment was left as it was found.

The next shift, RPN #110 documented that resident #001 was comfortable and

the RPN decreased the treatment to what the order had indicated.

On a specific date and time RPN #104 documented that the Pharmacy was called and a message was left on the answering machine indicating that RPN #104 could not locate the drug order page in the drug record book indicating that the medications had been ordered and received from the pharmacy for resident #001. The RPN requested that the pharmacy return the call.

On the same day, RPN #104 documented that resident #001 indicated that a piece of medical equipment was not working properly. RPN #104 assessed resident #001 and noted the equipment appeared to be working properly. A physical assessment of resident #001 was completed and the resident appeared stable. RPN #104 requested that RN #106 Supervisor also complete an assessment of the resident. Later that same day resident #001 experienced a near miss when he/she had difficulty transferring and required assistance.

On a specific date and time RN #106 documented that he/she spoke to resident #001 regarding the near miss. Health teaching was completed and implications were discussed with resident #001 by RN #106, if the outcome had been different. RN #106 instructed resident #001 to use the call bell and to keep it close to call for assistance if required. The RN discussed the use of a safety device and indicated staff may use it if the resident continued to not call for assistance. RN #106 informed RPN #107 Charge Nurse to notify the residents SDM.

On a specific date and time, RPN #107 indicated that he/she was informed regarding near miss that resident #001 had experienced. RN #106 also stated to RPN #107 that if resident continued to not ask for assistance when needed, then a safety device would be an option. The SDM was informed of this by RPN #107 and the SDM agreed with the plan of care.

On a specific date and time, RN #106 was called to resident #001's room, resident was in distress. The RN completed an assessment, attempted interventions and the decision was made to transfer the resident to hospital for emergent care. The SDM was notified of the transfer.

On a specific date and time, RPN #104 indicated that resident #001 rang the call bell and stated they were not feeling well. RPN #104 assessed Resident #001 as the resident appeared to be in distress. Day RN #106 supervisor was called

to assess the resident and the decision was made to send resident #001 to the hospital for further assessment.

On a specific date and time, RPN #104 documented that resident #001 only received one medication before being transferred to hospital as the ambulance had arrived before the other medications could be administered. Ambulance personnel were also informed of this.

During an interview on a specific date and time, RPN #111 indicated that he/she worked on a specific date and time. RPN #111 saw there were new orders written for resident #001 on the day prior. Three medications had been discontinued therefore the RPN did not administer them to resident #001. The new medications had not been received from pharmacy on the specified date. The RPN #111 told resident #001 that the medications were not available and if he/she needed the PRN medication to let the RPN know. RPN #111 indicated that a call was placed to the pharmacy, to inquire about the medications not being available, the pharmacy indicated that they had received the order and that one medication would be coming but they needed clarification from the Nurse Practitioner (NP) for the second medication. RPN #111 indicated that the NP was already gone for the day so he/she unable to clarify the order and he/she did not call the MD to clarify the order either. RPN #111 indicated that he/she did not document the call to the pharmacy. RPN #111 indicated that it was busy so he/she told RPN #108 to call the doctor and clarify the order.

On a specific date and time during an interview RPN #108 indicated that he/she did not contact the Physician or Nurse Practitioner to inform them the new medication was not available for resident #001 and the order for the second medication required clarification. The RPN indicated that he/she was notified by the Pharmacy on a specific date and time, that there was a problem with the medication order. RPN #108 indicated that he/she discussed it with RPN #110 to decide what to do. RPN #108 indicated that he/she did not notify the RN Supervisor about the new medications not being available. RPN #108 indicated that shift, he/she gave resident #001 the discontinued medications and did not seek direction from the Physician or Nurse Practitioner. The RPN #108 indicated that on that same date, resident #001 was receiving a specified treatment at a higher level than prescribed. The RPN decreased the treatment and attempted to reposition the resident. The RPN #108 received a phone call from the SDM to say that they were concerned about resident #001. When RPN #108 went to assess resident #001, distress was noted. The RPN #108

indicated that he/she increased the specified treatment to level not prescribed. RPN #108 indicated that he/she encouraged resident #001 to keep the specified treatment at the prescribed level. RPN #108 indicated that he/she advised resident #001 that there was PRN medications available if required. RPN #108 indicated he/she did not notify the RN Supervisor, the Physician or Nurse Practitioner that resident #001's assessed levels were low despite receiving the specified treatment.

On a specific date and time during an interview RPN#104 indicated that he/she was working on a specific date. RPN #104 discovered that there had been a change in medications for resident #001. The RPN #104 gave the resident some of the medications as ordered, but there was one medication missing. RPN #104 contacted the pharmacy to notify them that the medication had not been received. RPN #104 indicated that a message was left on the answering machine for the Pharmacy. RPN #104 indicated there was only one attempt made to contact the pharmacy, and at the end of the shift he/she realized that the pharmacy had not called back, so he/she let the Supervisor, RN #106 know. RPN #104 indicated that he/she did not contact the Physician or NP to notify them that the medication was not available, because he/she was waiting on the Pharmacy to call back. RPN #104 indicated that the report from the prior shift was that resident #001 had used a specified treatment at a higher rate than prescribed. When RPN #104 checked resident #001 the treatment was administered as ordered. RPN #104 indicated that he/she was asked to go see resident #001 because the resident felt that the specified treatment was not working. When RPN #104 checked the specified treatment, it was working properly and residents #001's assessment was stable. Reassurance was offered and RPN #104 requested that RN #106 speak to resident #001 about the concerns.
RPN #104 indicated that the following day, at the start of shift there was no mention at report of anything unusual for resident #001. RPN indicated that he/she did not further inquire about the missing medication. That morning resident #001 had breakfast in his/her room which was not unusual. RPN #104 was called to resident #001's room and was informed that the resident was in distress. RPN #104 took resident #001's scheduled medications to the room when he/she went to assess and administered it when it was discovered resident #001 was in distress. RPN #104 then called for RN #106 as there was obvious distress and resident #001 needed to be assessed. 911 was called by RN #106, RPN #104 indicated that he/she did not administer the PRN medication at that time as there was no chance to give it, the ambulance was

here quickly and they took over.

During an interview RN #106 indicated the following:
Resident #001 had a history of a specified diagnosis and used a specific treatment. On a specified date, RN #106 indicated that he/she received a call at a specific time from RPN #104 who reported that resident #001 had experienced a near miss. RN #106 indicated that he/she went to resident #001 and assess the situation. At the time resident #001 was coherent and not in distress. RN #106 indicated that a discussion was held with the resident about using the call bell to call for assistance. RN #106 indicated that at the end of the shift he/she instructed the evening RPN #107 to call the SDM for resident #001 and let them know that there was a near miss earlier in the day. The RN recalled receiving a phone call earlier in the day shift from RPN #104 indicating that resident #001 was concerned about his/her specific treatment. The RN #106 asked RPN #104 if resident #001 was in distress, but did not go see resident #001 at that time. RN #106 indicated that he/she was made aware of the change in medications for resident #001, on that same day as RPN #104 was not certain how to administer the medication. RN #106 indicated that RPN #104 did inform him/her that there was a second medication that had not been received from the pharmacy and the RN and RPN #104 both checked the medication cart to look for the medication. The medication was not located and RN #106 instructed RPN #104 to call the emergency pharmacy to find out where the medication was. RN #106 indicated that he/she did not follow up with RPN #104 to see if the medication had been received. RN #106 indicated that he/she was aware that there were changes in resident #001's medications but did not know exactly what medications resident #001 had been on or what the new orders indicated. RN #106 indicated that he/she did not look at the chart for resident #001 to see what was ordered and at no time did he/she contact the Physician or NP, or instruct the RPN to do so regarding the medication not being available. On a specified date, RN indicated that he/she was called by RPN #104 who stated that resident #001's was in distress. The RN went to assess, resident #001 was in obvious distress. The RN indicated that he/she attempted interventions and then informed resident #001 that they were sending him/her to the emergency room and called 911.

On a specific date and time during an interview Nurse Practitioner (NP) #105 indicated that he/she wrote the orders for resident #001 on a specific date, to stop three specific medications, and to initiate two new medications daily, a specific medication was also ordered as PRN. The NP indicated that it was

assumed that the medication would arrive that evening as the order was written before the 1500 hours cut off time. The NP was not made aware that the medications did not arrive in the home until the following evening or that only one of the medications actually arrived. The NP indicated that he/she first became aware of the problem of the medication not being available, six days after the order was written, and after the resident was already admitted to the hospital.

Staff and others involved in the different aspects of care for resident #001 failed to collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and compliment each other. As a result, medications were stopped before new medications were available, despite repeated complaints by resident #001 that he/she felt distressed, staff did not collaborate with the Physician, Nurse Practitioner or Pharmacy to alert them of the medications not being available and the change in condition of resident #001's health status which ultimately resulted in resident #001 experiencing distress, which required transfer to hospital. [s. 6. (4) (a)] (623)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 05, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 6th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Sarah Gillis

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