Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
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Telephone: (613) 569-5602
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Feb 9, 10, 13, 14, 15, 16, 17, 2012	2012_031194_0007	Complaint Log #000235-12

Licensee/Titulaire de permis

TENDERCARE NURSING HOMES LIMITED
212 Queen Street East, Suite 202, Sault Ste Marie, ON, P6A-5X8

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

TENDERCARE LIVING CENTRE
1020 McNICOLL AVENUE, SCARBOROUGH, ON, M1W-2J6

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with The Administrator, Assistant Director of Care (ADOC), Power of Attorney, six Registered Nurses (RN), 3 Registered Practical Nurses (RPN) and physician

During the course of the inspection, the inspector(s) reviewed the resident's clinical health records, relevant policies, Professional Advisory Committee minutes, medication incident reports

The following Inspection Protocols were used during this inspection:

Medication

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs
Specifically failed to comply with the following subsections:

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. A physician's order was received for an identified resident indicating: a specific dosage for a drug to be administered weekly until next supply then to resume previous dosage.

The identified drug was available in two different dosages at the home.

An identified nurse (#1) administered the prescribed drug to the resident, over a two day period.

An identified nurse (#2) did not administer to the resident the complete dosage prescribed.[s.131.(2)]

Additional Required Actions:

CO # - 901 was 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 subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Under Reg. O. 79/10, s.114(2)the licensee 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 off all drugs used in the home.

Licensee Policy (# 11-07) -"Ordering, receiving, recylcing and destruction" (reviewed, September 2010)indicates that:
- Pharmacy prescriptions ordered and dispensed for one resident, even if they are unopened are not to be used for another resident unless the situation is life threatening.
- Processing the physician order as per the contracted pharmacy process including the following:
a) Enter the item on the MAR or TAR sheet or in the electronic MAR or TAR database;
b)Enter the item in the Drug Record Book or follow the contracted pharmacies process for using the Drug Record Book
- Medications received will be checked against medications ordered either manually through the Drug Record Book or by scanning bar codes on the pouches and comparing with packing slips.

* An identified nurse (#1) administered a drug ordered and dispensed for another resident to the identified resident in December 2011.

* An identified nurse (#3) administered a drug ordered and dispensed for another resident to the identified resident in December, 2011.

* An identified nurse (#3) administered a drug ordered and dispensed for another resident to the identified resident in January 2012.

* The inspector interviewed the ADOC,3 RN's and 1 RPN at the home in regards to the ordering and receiving of an identified drug. All staff interviewed stated that they did not document the ordering or receiving of the identified drug.

Licensee Policy (#11-06) - "Physician/prescriber orders" (reviewed September 2010) indicates that:
- Registered Staff are responsible to complete all other tasks as follows related to processing the order depending on what has been ordered:
f) add the new order to the Drug Record Book if not other wise produced/supplied by the pharmacy

* The inspector interviewed the ADOC,3 RN's and 1 RPN at the home in regards to the ordering and receiving of an identified drug. All staff interviewed stated that they did not document the ordering or receiving of the identified drug.

Licensee Policy (#11-03) - "Medication pass" (reviewed September 2010) indicates that:
- Medications passes are to be completed as scheduled following the practices below:
- checking and confirming the 5 Rights:(Right resident,drug,dose,time,route)
- Administering all of the required medications to the resident

* An identified nurse (#1) administered the prescribed drug to the resident, over a two day period.

* An identified nurse (#2) did not administer to the resident the complete dosage prescribed.[s.131.(2)]

The Registered staff failed to administer the identified resident's drug at the right dose and time.

Additional Required Actions:

CO # - 902 was served on the licensee. Refer to the "Order(s) of the Inspector".

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

Specifically failed to comply with the following subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. An identified resident was admitted to the home in 2008. The identified resident had been receiving a specific drug for at least 2 years. The identified resident received routine monthly blood work. The identified resident received treatment in December, 2011 and January ,2012. ADOC confirmed that the identified resident had received this treatment in the past as well.

In December, 2011 the physician prescribed a treatment for the identified resident. Documentation in resident's clinical health record states that the treatment was given for pain control

In January, 2012 the progress notes indicate an entry by the physician indicating symptoms that the identified resident was exhibiting and suggesting possibilities related to recent treatments and under lying conditions.

The progress notes indicate that on five consecutive days in January, 2012 the identified resident had a low grade fever. The identified resident received treatment.

Progress notes indicate that on two separate incidents in January , 2012 the identified resident was complaining of feeling tired and lethargic. An identified nurse (#4) states that on the evening the identified resident was taken to hospital she noted the resident to be weak. The identified resident was noted to be verbally unresponsive by Power of Attorney, who expressed concern and wanted the resident to go to the hospital. Resident was taken to hospital and later admitted.

The plan of care for the identified resident does not provide clear direction to Registered Nursing staff related to monitoring of signs and symptoms related to treatments received or pre-existing condition.[s.6(1)(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 there is a written plan of care for all resident receiving the drug identified above, providing clear direction to the Registered Nursing staff and others who provide direct care to the resident related to side effects of the drug as well as management of pre-existing conditions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee did not submit a Critical Incident Report within 10 days of being aware of a medication incident in which a resident was taken to hospital.

The licensee became aware of a medication incident at the home resulting in a potential wrong dosage being administered. An identified resident as admitted to hospital in January 2012. The licensee notified the Director by telephone of the medication incident on January 27, 2012. A Critical Incident was not submitted by the licensee to the Director until February, 2012 [107.(3)5]

Issued on this 17th day of February, 2012

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Chantal Lafreniere (194)

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHANTAL LAFRENIERE (194)
Inspection No. / No de l'inspection :	2012_031194_0007
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Feb 9, 10, 13, 14, 15, 16, 17, 2012
Licensee / Titulaire de permis :	TENDERCARE NURSING HOMES LIMITED 212 Queen Street East, Suite 202, Sault Ste Marie, ON, P6A-5X8
LTC Home / Foyer de SLD :	TENDERCARE LIVING CENTRE 1020 McNICOLL AVENUE, SCARBOROUGH, ON, M1W-2J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	FRANCIS MARTIS

To TENDERCARE NURSING HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 901 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee 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)

Grounds / Motifs :

1. . A physician's order was received for an identified resident indicating: a specific dosage for a drug to be administered weekly until next supply then to resume previous dosage.

The identified drug was available in two different dosages at the home.

An identified nurse (#1) administered the prescribed drug to the resident, over a two day period.

An identified nurse (#2) did not administer to the resident the complete dosage prescribed.[s.131.(2)] (194)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 24, 2012

Order # / Ordre no : 902 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving to meet the requirement under O. Reg. 79/10, s.8(1)(b)

This plan is to include how the licensee's policies and procedures related to the accurate acquisition, dispensing , receipt, storage, and administration of all drugs used in the home is to be complied with including but not limited to:

- How the Registered Nursing staff will administer medications to residents as directed by the prescriber
- How the Registered Nursing staff will only administer medications dispensed for the residents
- How the licensee will ensure that a record of all drugs ordered and received are kept at the home

Grounds / Motifs :

1. Under Reg. O. 79/10, s.114(2)the licensee 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 off all drugs used in the home.

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* An identified nurse (#1) administered the prescribed drug to the resident, over a two day period.

* An identified nurse (#2) did not administer to the resident the complete dosage prescribed.[s.131.(2)]

The Registered staff failed to administer the identified resident's drug at the right dose and time. (194)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 02, 2012

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

See below

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing 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
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

See below.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto ON M5S 2B1
Fax: (416) 327-7603

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 17th day of February, 2012

Signature of Inspector / Signature de l'inspecteur : Chantal Lafrenière (194)

Name of Inspector / Nom de l'inspecteur : Chantal Lafreniere

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