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

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 Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 23, 2015	2015_389601_0028	031199-15, 031200-15, 031509-15, 033042-15	Follow up

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

REACHVIEW VILLAGE
130 REACH STREET UXBRIDGE ON L9P 1L3

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

KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): November 24, 25, 26,27, and December 3, 2015.

Also inspected were two follow up logs and two critical incidents logs:

Follow up log #031199-15 related to a Compliance Order #001 the home not following pain management and medication administration policies.

Follow up log #031200-15 related to Compliance Order #002 adminstration of drugs in accordance with directions by prescriber.

Critical Incident log # 031509-15 related to a critical incident the home submitted related to allegations of abuse to a resident.

Critical Incident log # 033042-15 related to a critical incident the home submitted related to a fall resulting in a transfer to hospital.

During the course of the inspection, the inspector(s) spoke with The Regional Manager Clinical Services, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapist, Personal Support Workers (PSW), and Residents.

The inspector observed resident care including staff-resident interactions, medication administration, reviewed residents health care records, minutes from registered staff meeting, medication incident reports, compliance history and policies related to medication administration and pain management, critical incidents,review of staff education records.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Medication
Pain

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

- **3 WN(s)**
- **0 VPC(s)**
- **3 CO(s)**
- **3 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 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 their policy related to medication administration was followed to ensure safe, effective administration of medications.

O.Reg. 79/10, 114. (2) states that the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration and destruction, and disposal of all drugs used in the home.

The home's Medication / Treatment Standards policy #LTC-F-20 last revised August 2012 states under National Operating Procedure:

The Pharmacy provider will be notified immediately if medication ordered is not available for administration. The Physician/Nurse Practitioner will be notified if a medication is not available. All medication administration, refused or omitted will be documented immediately after administration on the MAR/TAR using the proper codes by administering nurse. The Physician/Nurse Practitioner will be contacted, as appropriate, if medications are refused, held, or not available from the pharmacy (when ordered as urgent) for a twenty-four hour. Upon completion of the medication pass, ensure that all residents have been given their medication and the documentation has been completed.

Review of resident #001's Individual Narcotics and Controlled Drug Count Sheet for a narcotic medication was signed by RPN #119 on an identified date at 2215 hours. Review of resident #001's MAR from the specified date at 2000 hours indicated that RPN

#119 did not document the administration of the narcotic medication.

Review of resident #001's MAR for an identified date at 2000 hours indicated that two identified medication's were not documented as administered on the MAR by RPN #121. Therefore, the inspector was not able to determine if resident #001 received the medication's as prescribed by the Physician or if RPN#121 did not document the administration of the medication on resident #001's MAR.

Review of resident #001's MAR for an identified date at 1400 hours indicated that two identified medication's were not documented as administered on the MAR until sixteen days following the identified date at 2224hrs by RPN#113. Therefore, RPN#113 did not immediately document the medication administration on resident #001's MAR.

Review of resident #004's Individual Narcotics and Controlled Drug Count Sheet for a narcotic medication was signed by RPN#103 on an identified date. Review of resident #004's MAR for a two month period, indicated RPN #103 did not document the administration of the PRN narcotic medication on the identified date.

Review of resident #010's Individual Narcotics and Controlled Drug Count Sheet for a narcotic medication was signed by RPN#103 on two identified dates. Review of resident #010's MAR for a two month period, indicated RPN #103 did not document the administration of the PRN narcotic medication on the two identified dates. During an interview, RPN#103 admitted to not signing resident #010's MAR after administering the narcotic medication on the identified dates.

Review of resident #010's Individual Narcotics and Controlled Drug Count Sheet for a narcotic medication was signed by RPN #122 on an identified date. Review of resident #010's MAR for a two month period, indicated RPN #122 did not document the administration of the PRN narcotic medication on the identified date.

Review of resident #011's Physician's orders indicated to apply a topically treatment to resident #011's identified area twice daily as needed. RPN#114 indicated that resident #011's identified area was red and the topical reatment had been applied on an identified date. RPN #114 admitted to not signing resident #003's TAR immediately after the application of the topical treatment on the identified date.

During an interview, the Director of Care and the Regional Manager Clinical Services indicated that the administration of medications and treatment creams are to be

documented immediately on the MAR and TAR as per the homes policy. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: 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 failed to ensure that resident #001's and resident #003's drugs were administered in accordance to the directions for use as specified by the prescriber.

Review of resident #001's Physician orders for a specified date indicated the medication as needed order changed for an analgesic medication to one tablet by mouth every four hours as needed up to a maximum of three tablets per day.

During an interview, RPN#122 indicated holding resident #001's regular scheduled analgesic medication on an identified date at 0800hrs as prescribed by the Physician. The same analgesic medication that was ordered as needed was administered during the night at 0430hrs. Review of resident #001's progress notes on the identified date at 0713hrs indicated that resident #001 approached RPN #122 on several occasions indicating pain.

On an identified date, resident #001 received the regular dosage of analgesic medication at 0800hrs, 1200hrs and 1600hrs. Resident #001's Physician order indicated resident #001 may only receive a maximum of three PRN analgesic medication tablets in a twenty-four period and on an identified date resident #001 received five PRN analgesic

medication tablets. Resident #001 exceeded the maximum daily dosage of analgesic medication on the identified date.

During an interview, RN#112 indicated that on two identified dates and times resident #001 received a greater dosage of an analgesic medication and review of resident #001's MAR also identified the error.

Review of resident #001's Physician order for an identified date in October 2015 indicated to administer resident #001's narcotic medication with a specified dosage once daily for five days and if well tolerated the identified medication was to be given by mouth four times a day.

On an identified date in November 2015, resident #001's Physician orders indicated to increase the identified narcotic medication at 2100hrs.

Review of resident #001's Individual Narcotics and Controlled Drug Count Sheet for the identified date in November 2015 at 2025 hours indicated that the narcotic medication lower dose was documented by RPN#118 instead of the increased dose as ordered at bedtime. Review of resident #001's MAR indicated that the narcotic medication higher dose was administered. During an interview, RPN #118 indicated that resident #001 received the lower dose of the narcotic medication as documented on the Individual Narcotics and Controlled Drug Count Sheet for the identified date and time.

Therefore, on the identified date in November 2015 at 2025 hours, resident #001 received the lower dose of narcotic medication, contrary to the Physician's order to increase the narcotic medication at bedtime.

The Ministry of Health and Long Term Care received a written letter from resident #001 on an identified date indicating being stressed and afraid of the medication errors that keep occurring. Resident #001 restated the fear of repeated medication errors during an interview on an identified date.

On an identified date in November 2015 resident #003's Physician ordered a narcotic medication to be administered every four hours as needed for two weeks for pain management.

On an identified date in November 2015 at 1830 hours, resident #003 received two tablets of the wrong narcotic medication, contrary to the Physician order. During an

interview, the Assistant Director of Care (ADOC) indicated that RPN #113 realized the medication incident at change of shift on the identified date when checking resident #003's Individual Narcotics and Controlled Drug Count Sheet for the narcotic medication that had been ordered by the Physician. [s. 131. (2)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept for every medication incident involving a resident and that every adverse drug reaction was documented, reviewed, analyzed and that a corrective action was taken as necessary.

During the inspection four medication incidents were identified involving resident #003, #011, and #001. Resident #003 received the wrong narcotic medication, resident #011 topical cream was applied without documentation, resident #001 received the wrong dosage of a medication, and resident #001 analgesic topical treatment was not provided as prescribed by the Physician.

Regulation Definition for "medication incident" means a preventable event associated

with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a prescription, and includes,
(a)an act of omission or commission, whether or not it results in harm, injury or death to a resident, or
(b)a near miss event where an incident does not reach a resident but had it done so, harm, injury or death could have resulted;

The home's Medication / Treatment Standards policy #LTC-F-20 last revised August 2012 states under National Operating Procedure:

The Pharmacy provider will be notified immediately if medication ordered is not available for administration. The Physician/Nurse Practitioner will be notified if a medication is not available. All medication administration, refused or omitted will be documented immediately after administration on the MAR/TAR using the proper codes by administering nurse. The Physician/Nurse Practitioner will be contacted, as appropriate, if medications are refused, held, or not available from the pharmacy (when ordered as urgent) for a twenty-four hour. Upon completion of the medication pass, ensure that all residents have been given their medication and the documentation has been completed.

On an identified date in November 2015 resident #003's Physician ordered a narcotic medication one to two tablets every four hours as needed for pain times two weeks.

On an identified date in November 2015 at 1830 hours, resident #003 received the wrong narcotic medication, contrary to the Physician order.

During an interview, the Assistant Director of Care (ADOC) indicated that RPN#113 realized the medication incident had occurred at change of shift on the identified date in November when checking resident #003's Individual Narcotics and Controlled Drug Count Sheet for the identified narcotic medication. Therefore, a medication incident occurred on the identified date at 1830 hours resulting in resident #003 receiving the wrong medication.

Review of resident #011's Treatment Administration Record (TAR) for a three day period indicated a Physician's order to apply a topical treatment twice daily as needed to resident #011.

During an interview, RPN #114 indicated that resident #011 required the topical treatment on a evening shift during the three day period reviewed and the topical

treatment was applied. RPN#114 admitted to not signing resident #011's TAR on the identified date following application.

During a prior inspection #2015_347197_0031 issued on October 30, 2015, it was identified by Inspector #601 on an identified date in September 2015 that RPN #114 had applied resident #011's topical treatment on unidentified dates during a twenty-two day period and had not immediately documented on resident #011's TAR after application of the topical treatment.

During an interview, RPN#114 indicated no awareness of the medication incident that occurred sometime during September 2015 relating to resident #011's topical treatment and indicated a corrective action was not taken.

During an interview, the Director of Care (DOC) indicated the medication incident that was identified by Inspector #601 on the identified date involving resident #011 and RPN#114 was not documented, reviewed, analyzed, and corrective action was not taken.

Therefore, a medication incident occurred involving resident #011 and RPN#114 in a previous inspection and there was no evidence that a written record was kept for the medication incident involving resident #011, or that the medication incident was reviewed, analyzed and that a corrective action was taken as necessary.

Review of resident #001's Physician order on an identified date indicated one tablet of analgesic medication every four hours as needed to a maximum of three tablets per day - maximum daily dose of the analgesic medication was ordered by the Physician.

Review of resident #001's Physician Medication Review dated on an identified date indicated analgesic medication one to two tablets every four hours PRN. May only use maximum of three tablets in a twenty four hour period.

Review of resident #001's Physician phone order obtained by RN#117 on an identified date indicated analgesic medication one tablet by mouth every four hours as needed up to maximum of three tablets per day.

During a prior inspection #2015_347197_0031 issued on October 30, 2015, it was identified by Inspector #601 that on three identified dates resident #001 received a greater dose of an analgesic medication then prescribed by the Physician.

Review of the "Medication Incident Report" for resident #001 completed three days following the discovery of the medication incident. The Director of Care indicated on the "Medication Incident Report" that resident #001 had been given two tablets of an identified analgesic medication on an identified date and time and the corrective action identified was that clarification of the order was needed and to see the orders.

During an interview, the Pharmacist indicated that on an identified date while completing a medication audit for resident #001 it was identified that resident #001's as needed analgesic medication had exceeded the maximum of three tablets in a 24 hour period. The Pharmacist indicated that a call was placed immediately to RN#117 to report the medication incident.

During an interview, RN#117 indicated receiving a call from the Pharmacist on the day after the medication incident and was made aware that resident #001 had exceeded maximum daily dose of analgesic medication on an identified date and time. RN#117 indicated that the Pharmacist had recommended that resident #001's analgesic medication be changed to one tablet by mouth every four hours as needed up to maximum of three tablets per day. RN#117 indicated the Physician was made aware of the Pharmacist recommendations and resident #001's Physician changed the analgesic medication order back to one tablet by mouth every four hours as needed. RN#117 indicated a medication incident report was not completed and no further corrective action was taken.

Therefore, a medication incident occurred involving resident #001 on an identified dates in September 2015 resulting in resident #001 receiving an incorrect dose of an analgesic medication. A Medication Incident Report was completed on an identified date in October 2015 with corrective actions.

Subsequently, Resident #001 received an incorrect dosage of an analgesic medication on an identified date in November 2015 and there was no evidence that a written record was kept involving resident #001 on the identified date.

Review of Resident #001's Physician order for a two month period indicated to apply the topical treatment to resident #001's specified areas for pain relief.

Review of resident #001's Treatment Administration record (TAR) for a period of fourty-eight days indicated that RPN#119 documented that resident #001's topical treatment

was held on an identified date and two identified times and to see the progress notes. Review of resident #001's progress notes for the identified date and times does not explain the reason the topical treatment was not applied as prescribed by the Physician.

Review of resident #001's TAR for a period of fourty-eight days indicated that the topical treatment was documented as not available on eleven occasions. RPN#119 documented that the topical treatment was not available on ten occasions and RPN #121 documented that the topical Vita rub was not available on one occasion.

Review of resident #001's TAR for a period of fourty-eight days indicated that the topical treatment was not signed as administered on twelve occasions.

Review of resident #001's TAR for a period of fourty-eight days indicated that the topical treatment was documented as drug refused on twenty four occasions.

Review of resident #001's progress notes for a period of fourty-eight days indicated that resident #001 was experiencing pain and had reported the topical treatment caused discomfort, and doesn't help when applied. Resident #001 also refused the application of the topical treatment reporting an allergy to the treatment and it wasn't necessary due to not having pain in the area the Physician had ordered the topical treatment to be applied.

During an interview, RPN#103, RPN #110, RPN#111, and RPN#122 indicated that resident #001 reported that the topical treatment caused discomfort and refused the topical treatment for pain management on several occasions during the identified two month period.

Therefore, resident #001 did not receive the topical treatment as prescribed by the Physician for pain management on thirty-three occasions during a fourty-eight day period due to the topical treatment being held, not available, not signed as administered and refused by resident #001. There was no evidence that a written record was kept for every medication incident involving resident #001, that the adverse drug reaction was reported to the Physician, that the medication incidents was reviewed, analyzed and that a corrective action was taken as necessary. [s. 135. (2)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

Issued on this 31st day of December, 2015

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

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) :	KARYN WOOD (601)
Inspection No. / No de l'inspection :	2015_389601_0028
Log No. / Registre no:	031199-15, 031200-15, 031509-15, 033042-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Dec 23, 2015
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	REACHVIEW VILLAGE 130 REACH STREET, UXBRIDGE, ON, L9P-1L3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michael MacDonald

To REVERA LONG TERM CARE 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)

Linked to Existing Order / Lien vers ordre existant: 2015_347197_0031, CO #001;

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:

(a) educate all registered nursing staff about the licensee's Medication/Treatment Standards Policy #LTC-F-20 in a formal education session, and evaluate staff comprehension of the contents of the Policy following the session; in particular the session and evaluation must include the requirement in the Policy to immediately document following medication administration, including narcotics and treatment creams; and

(b) develop and implement a process to ensure that all staff who administer medication to residents adhere to the home's Medication/Treatment Standards Policy #LTC-F-20 , and to ensure that prompt action is taken in response to non-compliance with this Policy.

Grounds / Motifs :

1. The licensee has failed to ensure that their policy related to medication administration was followed to ensure safe, effective administration of medications.

O.Reg. 79/10, 114. (2) states that the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure

accurate acquisition, dispensing, receipt, storage, administration and destruction, and disposal of all drugs used in the home.

The home's Medication / Treatment Standards policy #LTC-F-20 last revised August 2012 states under National Operating Procedure:

The Pharmacy provider will be notified immediately if medication ordered is not available for administration. The Physician/Nurse Practitioner will be notified if a medication is not available. All medication administration, refused or omitted will be documented immediately after administration on the MAR/TAR using the proper codes by administering nurse. The Physician/Nurse Practitioner will be contacted, as appropriate, if medications are refused, held, or not available from the pharmacy (when ordered as urgent) for a twenty-four hour. Upon completion of the medication pass, ensure that all residents have been given their medication and the documentation has been completed.

Review of resident #001's Individual Narcotics and Controlled Drug Count Sheet for a narcotic medication was signed by RPN #119 on an identified date at 2215 hours. Review of resident #001's MAR from the specified date at 2000 hours indicated that RPN #119 did not document the administration of the narcotic medication.

Review of resident #001's MAR for an identified date at 2000 hours indicated that two identified medication's were not documented as administered on the MAR by RPN #121. Therefore, the inspector was not able to determine if resident #001 received the medication's as prescribed by the Physician or if RPN#121 did not document the administration of the medication on resident #001's MAR.

Review of resident #001's MAR for an identified date at 1400 hours indicated that two identified medication's were not documented as administered on the MAR until sixteen days following the identified date at 2224hrs by RPN#113. Therefore, RPN#113 did not immediately document the medication administration on resident #001's MAR.

Review of resident #004's Individual Narcotics and Controlled Drug Count Sheet for a narcotic medication was signed by RPN#103 on an identified date. Review of resident #004's MAR for a two month period, indicated RPN #103 did not document the administration of the PRN narcotic medication on the identified

date.

Review of resident #010's Individual Narcotics and Controlled Drug Count Sheet for a narcotic medication was signed by RPN#103 on two identified dates. Review of resident #010's MAR for a two month period, indicated RPN #103 did not document the administration of the PRN narcotic medication on the two identified dates. During an interview, RPN#103 admitted to not signing resident #010's MAR after administering the narcotic medication on the identified dates.

Review of resident #010's Individual Narcotics and Controlled Drug Count Sheet for a narcotic medication was signed by RPN #122 on an identified date. Review of resident #010's MAR for a two month period, indicated RPN #122 did not document the administration of the PRN narcotic medication on the identified date.

Review of resident #011's Physician's orders indicated to apply a topically treatment to resident #011's identified area twice daily as needed. RPN#114 indicated that resident #011's identified area was red and the topical treatment had been applied on an identified date. RPN #114 admitted to not signing resident #003's TAR immediately after the application of the topical treatment on the identified date.

During an interview, the Director of Care and the Regional Manager Clinical Services indicated that the administration of medications and treatment creams are to be documented immediately on the MAR and TAR as per the homes policy.

The non-compliance with O.Reg. 79/10, s. 8(1)(b), O.Reg. 79/10, 114. (2) this order is being issued based on the fact that the Medication Administration / Treatment Standards Policy #LTC-F-20 was not complied with in relation to immediate documentation following medication administration was not completed on ten occasions and there was no evidence that the licensee had a monitoring process in place to ensure that the Medication / Treatment Standards Policy #LTC-F-20 was complied with. It was identified that four out of six residents received medication without immediate documentation following administration. Therefore, there is a risk of medication dispensing errors as staff had not documented the medication being given and the residents may potentially receive the medication again. In addition, the compliance history of the licensee includes an order on October 30, 2015, and a non-compliance in a

similar area on October 28, 2013 related to medication administration. (601)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_347197_0031, CO #002;

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:

(a) develop and implement a process to ensure that medication is administered to all residents in accordance with the directions for use, as specified by the prescriber; and

(b) educate all registered nursing staff related to the College of Nurses of Ontario Medication Practice Standard, including administration of narcotics, the management of medication errors, and appropriate action to be taken in response to any medication error.

Grounds / Motifs :

1. The licensee failed to ensure that resident #001's and resident #003's drugs were administered in accordance to the directions for use as specified by the prescriber.

Review of resident #001's Physician orders for a specified date indicated the medication as needed order changed for an analgesic medication to one tablet by mouth every four hours as needed up to a maximum of three tablets per day.

During an interview, RPN#122 indicated holding resident #001's regular scheduled analgesic medication on an identified date at 0800hrs as prescribed by the Physician. The same analgesic medication that was ordered as needed was administered during the night at 0430hrs. Review of resident #001's progress notes on the identified date at 0713hrs indicated that resident #001

approached RPN #122 on several occasions indicating pain.

On an identified date, resident #001 received the regular dosage of analgesic medication at 0800hrs, 1200hrs and 1600hrs. Resident #001's Physician order indicated resident #001 may only receive a maximum of three PRN analgesic medication tablets in a twenty-four period and on an identified date resident #001 received five PRN analgesic medication tablets. Resident #001 exceeded the maximum daily dosage of analgesic medication on the identified date.

During an interview, RN#112 indicated that on two identified dates and times resident #001 received a greater dosage of an analgesic medication and review of resident #001's MAR also identified the error.

Review of resident #001's Physician order for an identified date in October 2015 indicated to administer resident #001's narcotic medication with a specified dosage once daily for five days and if well tolerated the identified medication was to be given by mouth four times a day.

On an identified date in November 2015, resident #001's Physician orders indicated to increase the identified narcotic medication at 2100hrs.

Review of resident #001's Individual Narcotics and Controlled Drug Count Sheet for the identified date in November 2015 at 2025 hours indicated that the narcotic medication lower dose was documented by RPN#118 instead of the increased dose as ordered at bedtime. Review of resident #001's MAR indicated that the narcotic medication higher dose was administered. During an interview, RPN #118 indicated that resident #001 received the lower dose of the narcotic medication as documented on the Individual Narcotics and Controlled Drug Count Sheet for the identified date and time.

Therefore, on the identified date in November 2015 at 2025 hours, resident #001 received the lower dose of narcotic medication, contrary to the Physician's order to increase the narcotic medication at bedtime.

The Ministry of Health and Long Term Care received a written letter from resident #001 on an identified date indicating being stressed and afraid of the medication errors that keep occurring. Resident #001 restated the fear of repeated medication errors during an interview on an identified date.

On an identified date in November 2015 resident #003's Physician ordered a narcotic medication to be administered every four hours as needed for two weeks for pain management.

On an identified date in November 2015 at 1830 hours, resident #003 received two tablets of the wrong narcotic medication, contrary to the Physician order. During an interview, the Assistant Director of Care (ADOC) indicated that RPN #113 realized the medication incident at change of shift on the identified date when checking resident #003's Individual Narcotics and Controlled Drug Count Sheet for the narcotic medication that had been ordered by the Physician.

On October 30, 2015 a compliance order issued for O. Reg. 79/10, r. 131(1) and (2) indicated that a monitoring process was to be put into place and to ensure that the Medication / Treatment Standards Policy #LTC-F-20 was complied with by November 23, 2015.

During the follow up inspection initiated on November 24, 2015 Inspector #601 identified over a three month period resident #001's analgesic medication was not administered as prescribed on four occasions and resident #001's narcotic was not administered on one occasion as prescribed. Resident #003 was also identified as receiving the wrong narcotic on one occasion as prescribed.

During an interview, the Director of Care and the Regional Manager of Clinical Services indicated not being aware of the medication incidents identified by Inspector #601 for resident #001 and a monitoring process had not been put into place as required in the compliance order issued on October 30, 2015.

The non-compliance with O.Reg. 79/10, r. 131(2) this order is being issued based on the fact that medication was not provided as prescribed and there was an absence of a monitoring process in place to ensure safe administration of medication. Two out of six residents were identified as not receiving medication as prescribed by the Physician. Therefore, there is a risk of harm and potential adverse side effects related to the medication incidents and the lack of monitoring to uncover medication errors. In addition, the compliance history of the licensee includes an order on October 30, 2015, a non-compliance in the same area on March 13, 2014 and a non-compliance in a similar area July 6, 2015. (601)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

(a) develop and implement a formal monitoring process that shall be put into place to evaluate medication administration processes to promptly address medication incidents to prevent re-occurrence and avoid adverse medication incidents; and

(b) analyze the home's medication administration for every resident over the thirty days following the issuance of the order to determine if there are medication incidents requiring evaluation and corrective action for the purpose of reducing medication incidents; and

(c) take appropriate action in response to all medication incidents.

Grounds / Motifs :

1. The licensee has failed to ensure that a written record was kept for every medication incident involving a resident and that every adverse drug reaction was documented, reviewed, analyzed and that a corrective action was taken as necessary.

During the inspection four medication incidents were identified involving resident #003, #011, and #001. Resident #003 received the wrong narcotic medication,

resident #011 topical cream was applied without documentation, resident #001 received the wrong dosage of a medication, and resident #001 analgesic topical treatment was not provided as prescribed by the Physician.

Regulation Definition for "medication incident" means a preventable event associated with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a prescription, and includes,
(a)an act of omission or commission, whether or not it results in harm, injury or death to a resident, or
(b)a near miss event where an incident does not reach a resident but had it done so, harm, injury or death could have resulted;

The home's Medication / Treatment Standards policy #LTC-F-20 last revised August 2012 states under National Operating Procedure:

The Pharmacy provider will be notified immediately if medication ordered is not available for administration. The Physician/Nurse Practitioner will be notified if a medication is not available. All medication administration, refused or omitted will be documented immediately after administration on the MAR/TAR using the proper codes by administering nurse. The Physician/Nurse Practitioner will be contacted, as appropriate, if medications are refused, held, or not available from the pharmacy (when ordered as urgent) for a twenty-four hour. Upon completion of the medication pass, ensure that all residents have been given their medication and the documentation has been completed.

On an identified date in November 2015 resident #003's Physician ordered a narcotic medication one to two tablets every four hours as needed for pain times two weeks.

On an identified date in November 2015 at 1830 hours, resident #003 received the wrong narcotic medication, contrary to the Physician order.

During an interview, the Assistant Director of Care (ADOC) indicated that RPN#113 realized the medication incident had occurred at change of shift on the identified date in November when checking resident #003's Individual Narcotics and Controlled Drug Count Sheet for the identified narcotic medication. Therefore, a medication incident occurred on the identified date at 1830 hours resulting in resident #003 receiving the wrong medication.

Review of resident #011's Treatment Administration Record (TAR) for a three day period indicated a Physician's order to apply a topical treatment twice daily as needed to resident #011.

During an interview, RPN #114 indicated that resident #011 required the topical treatment on a evening shift during the three day period reviewed and the topical treatment was applied. RPN#114 admitted to not signing resident #011's TAR on the identified date following application.

During a prior inspection #2015_347197_0031 issued on October 30, 2015, it was identified by Inspector #601 on an identified date in September 2015 that RPN #114 had applied resident #011's topical treatment on unidentified dates during a twenty-two day period and had not immediately documented on resident #011's TAR after application of the topical treatment.

During an interview, RPN#114 indicated no awareness of the medication incident that occurred sometime during September 2015 relating to resident #011's topical treatment and indicated a corrective action was not taken.

During an interview, the Director of Care (DOC) indicated the medication incident that was identified by Inspector #601 on the identified date involving resident #011 and RPN#114 was not documented, reviewed, analyzed, and corrective action was not taken.

Therefore, a medication incident occurred involving resident #011 and RPN#114 in a previous inspection and there was no evidence that a written record was kept for the medication incident involving resident #011, or that the medication incident was reviewed, analyzed and that a corrective action was taken as necessary.

Review of resident #001's Physician order on an identified date indicated one tablet of analgesic medication every four hours as needed to a maximum of three tablets per day - maximum daily dose of the analgesic medication was ordered by the Physician.

Review of resident #001's Physician Medication Review dated on an identified date indicated analgesic medication one to two tablets every four hours PRN. May only use maximum of three tablets in a twenty four hour period.

Review of resident #001's Physician phone order obtained by RN#117 on an identified date indicated analgesic medication one tablet by mouth every four hours as needed up to maximum of three tablets per day.

During a prior inspection #2015_347197_0031 issued on October 30, 2015, it was identified by Inspector #601 that on three identified dates resident #001 received a greater dose of an analgesic medication then prescribed by the Physician.

Review of the "Medication Incident Report" for resident #001 completed three days following the discovery of the medication incident. The Director of Care indicated on the "Medication Incident Report" that resident #001 had been given two tablets of an identified analgesic medication on an identified date and time and the corrective action identified was that clarification of the order was needed and to see the orders.

During an interview, the Pharmacist indicated that on an identified date while completing a medication audit for resident #001 it was identified that resident #001's as needed analgesic medication had exceeded the maximum of three tablets in a 24 hour period. The Pharmacist indicated that a call was placed immediately to RN#117 to report the medication incident.

During an interview, RN#117 indicated receiving a call from the Pharmacist on the day after the medication incident and was made aware that resident #001 had exceeded maximum daily dose of analgesic medication on an identified date and time. RN#117 indicated that the Pharmacist had recommended that resident #001's analgesic medication be changed to one tablet by mouth every four hours as needed up to maximum of three tablets per day. RN#117 indicated the Physician was made aware of the Pharmacist recommendations and resident #001's Physician changed the analgesic medication order back to one tablet by mouth every four hours as needed. RN#117 indicated a medication incident report was not completed and no further corrective action was taken.

Therefore, a medication incident occurred involving resident #001 on an identified dates in September 2015 resulting in resident #001 receiving an incorrect dose of an analgesic medication. A Medication Incident Report was completed on an identified date in October 2015 with corrective actions.

Subsequently, Resident #001 received an incorrect dosage of an analgesic medication on an identified date in November 2015 and there was no evidence that a written record was kept involving resident #001 on the identified date.

Review of Resident #001's Physician order for a two month period indicated to apply the topical treatment to resident #001's specified areas for pain relief.

Review of resident #001's Treatment Administration record (TAR) for a period of fourty-eight days indicated that RPN#119 documented that resident #001's topical treatment was held on an identified date and two identified times and to see the progress notes. Review of resident #001's progress notes for the identified date and times does not explain the reason the topical treatment was not applied as prescribed by the Physician.

Review of resident #001's TAR for a period of fourty-eight days indicated that the topical treatment was documented as not available on eleven occasions. RPN#119 documented that the topical treatment was not available on ten occasions and RPN #121 documented that the topical Vita rub was not available on one occasion.

Review of resident #001's TAR for a period of fourty-eight days indicated that the topical treatment was not signed as administered on twelve occasions.

Review of resident #001's TAR for a period of fourty-eight days indicated that the topical treatment was documented as drug refused on twenty four occasions.

Review of resident #001's progress notes for a period of fourty-eight days indicated that resident #001 was experiencing pain and had reported the topical treatment caused discomfort, and doesn't help when applied. Resident #001 also refused the application of the topical treatment reporting an allergy to the treatment and it wasn't necessary due to not having pain in the area the Physician had ordered the topical treatment to be applied.

During an interview, RPN#103, RPN #110, RPN#111, and RPN#122 indicated that resident #001 reported that the topical treatment caused discomfort and refused the topical treatment for pain management on several occasions during the identified two month period.

Therefore, resident #001 did not receive the topical treatment as prescribed by the Physician for pain management on thirty-three occasions during a fourty-eight day period due to the topical treatment being held, not available, not signed as administered and refused by resident #001. There was no evidence that a written record was kept for every medication incident involving resident #001, that the adverse drug reaction was reported to the Physician, that the medication incidents was reviewed, analyzed and that a corrective action was taken as necessary.

The non-compliance with O.Reg. 79/10, 135(2)(a)(b)(c) this order is being issued as a compliance order based on the fact that during the follow up inspection initiated on November 24, 2015 related to O.Reg 79/10, s. 131. (2), Inspector #601identified three medication incidents. Resident #003 was given the wrong narcotic. Resident #001 exceeded the daily maximum dose of an analgesic medication on an identified date and also did not receive the topical treatment as prescribed by the Physician on thirty-three separate occasions for a period of fourty-eight days. During the September 2015 inspection it was identified that resident #001 had received the wrong dose of analgesic medication on three occasions and it was also identified that there was a Physician's order for resident #001 to receive a different topical treatment that was never applied as ordered by the Physician and that resident #001 received a topical treatment that was not prescribed by the physician. Therefore, a written record was not kept for every medication incident involving a resident and that every adverse drug reaction was not documented, reviewed, analyzed and that a corrective action was not taken as necessary. In addition, the compliance history of the licensee related to a similar area on September 11, 2015, indicated previous non-compliance related to medication administration. (601)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2016

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
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 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
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 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
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 23rd day of December, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Karyn Wood

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