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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 15, 2016	2016_389601_0003	034181-15, 036506-15, 036507-15, 036508-15	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), SARAH GILLIS (623)

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): February 8, 9, 10, 11, and 12, 2016.

Three follow up intakes and one complaint log linked to a critical incident were inspected:

Follow up inspection log #036506-15 related to a Director Referral and Compliance Order #001, O. Reg. 79/10, s.8(1)(b) the licensee not following pain management and medication administration policies.

Follow up inspection log #036507-15 related to a Director Referral and Compliance Order #002, O. Reg. 79/10, s. 131(2)administration of drugs in accordance with directions by prescriber.

Follow up inspection log #036508-15 related to a Director Referral and Compliance Order #003, O. Reg. 79/10, s.135(2) medication incident analysis and documentation.

Complaint inspection log #034181-15 was linked to Critical incident #2635-000036-15 related to medication administration.

The previous Order issued on October 30, 2015 with the inspection number 2015_347197_0031, O. Reg. 79/10, s.8. (1)(b), O. Reg. 79/10, 48.(1)4 related to the licensee Pain Assessment and Symptom Management policy #LTC-E-80 was found to be in compliance at the time of this inspection.

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

**The inspector's 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 incident, review of staff education records and monitoring process for medication management.**

**The following Inspection Protocols were used during this inspection:
Medication
Pain
Personal Support Services**

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

- **3 WN(s)**
- **0 VPC(s)**
- **2 CO(s)**
- **2 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #001	2015_389601_0028	601

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. 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 :

The licensee has failed to comply with O. Reg. 79/10, r. 131 (1) by not ensuring that no drug was used by or administered to resident #007 and #012 unless the drug was

prescribed for the resident.

Related to resident #007:

During an interview, resident #007 indicated the PSWs had been applying the identified treatment cream to sore knees in the morning and at bedtime since returning from the hospital on an identified date.

Review of resident #007's Medication Reconciliation Admission Order form identified that the Physician had not ordered the identified treatment cream upon resident #007's return from the hospital on the identified date.

During an interview, PSW #113 indicated applying the identified treatment cream to resident #007's legs on two identified dates following the residents return from hospital.

During an interview, RPN#114 indicated that resident #007 had an order for the identified treatment cream and review of resident #007's TAR identified that RPN #114 had documented the identified treatment cream had been administered on two occasions since the resident returned from the hospital.

According to Pharmacist #110 the identified treatment cream for resident #007 was entered into the e-TAR for resident #007's for identified area twice a day prior to transfer to hospital on an identified date. Pharmacist #110 indicated that when resident #007 returned from the hospital the identified treatment cream remained on the e-TAR despite not being ordered by the Physician.

Therefore, the identified treatment cream was being applied to resident #007's identified area and the treatment cream had not been prescribed by the Physician upon return from the hospital on an identified date.

Related to resident #012:

During an interview on an identified date, resident #012 indicated that a cream was being applied to an identified area when required. Resident #012 indicated the PSWs will apply the cream at night before going to bed and the cream is not applied every night, just when required to the area identified.

Review of resident #012's Physician order identified that the treatment cream was

finished ten days prior to the resident indicating that the PSWs were still applying the treatment cream.

During an interview, PSW #116 indicated that resident #012 had a treatment cream for an identified area and the cream was applied on two identified dates after the treatment cream was finished.

During an interview, RPN #117 indicated resident #012 had an order to apply the treatment cream identified and the treatment cream was given to the PSW to apply on an identified date after the medication was discontinued.

Review of resident #012's progress notes for on an identified date identified that RPN#114 had documented that resident #012's identified area was improving and the identified treatment cream was still needed.

Therefore, the identified treatment cream was being applied to resident #012's identified area and the treatment cream had been discontinued by the Physician on ten days prior.

The licensee failed to comply with O. Reg. 79/10, r. 131(2) by not ensuring that resident #007's drugs were administered to the resident in accordance with the directions for use as specified by the prescriber.

Resident #007 returned from the hospital on an identified date.

Review of resident #007's Medication Administration Record (MAR) on the day after the resident returned from the hospital identified that RPN #118 had documented the 0800 hour medication as not available.
During an interview, RPN #118 indicated that ten identified medications were not administered to resident #007 as prescribed on the identified date and the medication was not signed as administered due to the medication not being available.

Resident #007 had three identified medications that were ordered by the Physician for twice daily and was scheduled to be administered at 1600 hours.

During an interview with Inspector #601, RPN #118 indicated being informed by the night nurse that resident #007's medication had been ordered and would be arriving the morning resident did not receive the medication. RPN #118 indicated that on the

identified date at approximately 1200 hours the ADOC informed RPN #118 that resident #007's medication had arrived from the Pharmacy. RPN #118 indicated that resident #007's medication remained in the ADOC's office until approximately 1300 hours while RPN #118 assisted other residents with their lunch meal. RPN #118 indicated that resident #007's 0800 hours medication were documented as not available because the medication arrived from the identified Pharmacy later in the day and the time frame exceeded the scheduled administration time as per the home's policy. RPN #118 also indicated not calling the Physician for direction about the medication not being available on the identified date and time as prescribed and using clinical judgment to not give the 0800 hour medication to resident #007 on the identified date.

Therefore, resident #007 did not receive ten identified medications on the identified date at 0800 hours as prescribed by the Physician.

Related to resident #007:

During an interview, resident #007 indicated that the PSWs have been applying a treatment cream twice a day since returning from the hospital six days prior.

Record review of resident #007's health care record indicated a Physician order to apply an identified treatment cream to a specific area twice a day when the resident returned from the hospital.
During an interview, Pharmacist #110 indicated the identified topical cream was entered into the e-MAR incorrectly and it would only prompt the nurse to sign for the identified topical cream once a day instead of twice daily as ordered by the Physician.

During an interview, PSW #119 indicated providing personal care to resident #007 on two evening shifts since the resident returned from the hospital. PSW #119 indicated that resident #007 does not have an order for a treatment cream since returning from the hospital.

During an interview, RPN #114 indicated that resident #007's Physician order was for an identified treatment cream to be applied to a specific area during the day shift only and that resident #007's identified treatment cream was not applied on an identified date four days following the resident's return from the hospital on the evening shift.

Therefore, resident #007's identified treatment cream was not being applied to resident #007's identified area twice daily as prescribed by the Physician.

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. 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 :

The licensee formal monitoring process for medication incidents failed to identify a medication transcribing error for resident #013 and failed to identify medication incidents for resident #007 and #012.The licensee also failed to ensure 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 for resident #007 and #012.

During an interview, the Regional Clinical Manager indicated a formal medication monitoring process was put into place for all residents by generating a Physician's Orders Audit Report in PCC e-MAR system every twelve hours to monitor medication administration and identify medication errors.

During an interview, the ADOC indicated that on an identified date and time, RN #123 administered resident #013's identified medication prior to transcribing the order in the e-MAR system.

Review of the licensee's Point Click Care (PCC) e-Mar Policy Number 9.3 - Ordering New Prescriptions Using Point Click Care indicated the following: All new prescriber orders must be entered in Point Click Care to populate the e-MAR; this process may be completed by the nurse upon receipt of a new prescriber order.

The next day, RN #120 was reviewing the PCC e-MAR for resident #013 and noted the identified medication was required to be administered at 0830 hours. RN #120 contacted RN #123 because the RN who transcribed the order was not working and couldn't have entered the identified medication in PCC e-MAR. It was discovered that RN #123 had administered resident #013's identified medication on the day prior at 0830 hours and the administration of the medication had not been documented at that time.

During an interview, the ADOC indicated that RN #123 did not transcribe the order for resident #013's identified medication prior to administration and because the 0830 hours administration time had already past the PCC e-MAR system generated the identified medication to be given on the following day at 0830 hours.

Therefore, the licensee's formal monitoring process put in place did not identify a potential medication error that could have occurred on the identified date at 0830 hours. RN #123 did not enter the identified medication on PCC e-MAR upon receipt of a new prescribed order and the identified medication was not documented immediately after administration in the e-MAR on the day it was administered at 0830 hours as per the licensee's policies.

During an interview, the ADOC indicated not being aware that resident #007's identified treatment cream and resident #012's identified treatment cream were being applied without being prescribed by the Physician.

During an interview, the ADOC also indicated not being aware that resident #007 did not receive medication as prescribed by the Physician on an identified date and was not aware that resident #007's identified treatment cream prescribed by the Physician to be applied twice daily was not being applied as specified.

Therefore, resident #007 and #012's medication incidents were not identified by the formal monitoring process put into place by the licensee and the drug reaction was not documented, reviewed, analyzed and a corrective action was not taken as necessary to prevent re-occurrence.

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. 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 :

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

A representative from licensee left a message for the SAO manager on an identified date, stating that the home had a power outage. The representative wanted to share with the SAO manager how the outage affected the e-MAR.

During an interview with Inspector #601, the Regional Clinical Manager indicated the power outage was not very long but the e-MAR was not working and the nurses were required to document the medication administration on a paper MAR or the e-MAR when

the power outage was over.

Record review of resident #002's Medication Administration Record (MAR) for a one month period identified that on the identified date and time that two identified medications had not been signed as administered. During an interview with Inspector #601, the Regional Clinical Manager identified that resident #002's medication was documented as administered on the e-MAR after the power outage on the identified date.

The Regional Clinical Manager also indicated some medication incidents had occurred on an identified date and time during the same month and it was discovered by the ADOC during a random medication audit that was being completed as part of the licensee's corrective action plan for medication administration.

On the identified date and time, the ADOC initiated the medication audit to observe RPN #121 administer medications. The ADOC indicated that during the medication observation it was identified that RPN#121 was not administering and documenting medication administration as per policy #LTC-F-20. The ADOC indicated that RPN #121 was made aware of the concerns related to the medication practice being observed. The ADOC indicated that RPN #121 became upset and left the building without completing the medication administration and the documentation of the medication already administered.

The home’s Medication / Treatment Standards policy #LTC-F-20 last revised January 2016 states under National Operating Procedure stated the following: All medication administration, refused or omitted will be documented immediately after administration on the MAR/TAR using the proper codes by administering nurse. Scheduled medications will be administered according to standard medication administration times. Medication should be given within the recommended time frame, 60minutes prior to and 60 minutes after the scheduled administration time.

Review of resident #001 Medication Administration Records (MAR) from the identified date and time indicated that RPN #121 did not document the administration of three identified medications.
Review of resident #002 MAR from the identified date and time indicated that RPN#121 did not document the administration of two identified medications.

Review of resident #006 MAR from the identified date and time indicated that RPN #121 did not document the administration of two identified medications.

Review of resident #007 MAR from the identified date and time indicated that RPN#121 did not document the administration of one identified medication.

Review of resident #014 MAR from the identified date and time indicated that RPN#121 did not document the administration of one identified medication.

Review of resident #015 MAR from the identified date and time indicated that RPN#121 did not document the administration of one identified medications.

Review of resident #016 MAR from the identified date and time indicated that RPN#121 did not document the administration of four identified medications.

Review of resident #017 MAR from the identified date and time indicated that RPN #121 did not document the administration of two identified medications.

Review of resident #018 MAR from the identified date and time indicated that RPN #121 did not document the administration of three identified mediations.

Review of resident #019 MAR from the identified date and time indicated that RPN #121 did not document the administration of one identified medication.

Review of resident #020 MAR from the identified date and time indicated that RPN #121 did not document the administration of two identified medications.

Review of resident #021 MAR from the identified date and time indicated that RPN #121 did not document the administration of one identified medication.

During an interview, RN #122 indicated being asked by the ADOC to complete the medication administration on the identified date and time, as RPN #121 did not return to work. RN #122 indicated that it was difficult to determine what medications were given by RPN #121 because there was no documentation. If the resident had an order for medications that was scheduled for the identified time and there was not a pouch in the cart then it was assumed that all scheduled medications had been given by RPN #121. RN #122 could not get confirmation from RPN #121 to determine if the medications had been administered as ordered and RPN #121 had not documented on the MAR for resident #001, #002, #006, #007, #014, #015, #016, #017, #018, #019, #020 and #021 on the identified date and time.

During an interview, the Regional Clinical Manager indicated that there was no identified negative outcome with the residents who did not receive their medication as per the home's policy and there was no way to confirm that the residents identified received their medication as ordered by the Physician on the identified date and time. The Regional Clinical Manager also indicated that the administration of medications and treatment creams are to be documented immediately on the MAR and TAR as per the homes policy. (623)

A compliance order was issued for O. Reg. 79/10, r.8. (1)(b), under O. Reg. 79/10, 114. (2) on December 23, 2015, during inspection number 2015_389601-0028 with a compliance date of January 31, 2016.

Issued on this 15th day of April, 2016

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
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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KARYN WOOD (601), SARAH GILLIS (623)
Inspection No. / No de l'inspection :	2016_389601_0003
Log No. / Registre no:	034181-15, 036506-15, 036507-15, 036508-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Apr 15, 2016
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 :	Shelley Fazackerley

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_389601_0028, 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 :

a) ensure that all staff who administer medication, including medicated treatment creams participate in the re-education of the College of Nurses of Ontario Medication Practice Standard, including administration of medication by unregulated care providers;

b) develop and implement an effective monitoring system to monitor all parts of medication administration, including treatment creams to ensure that all medication are administered to all residents in accordance with the directions for use, as specified by the prescriber; and that this is done in partnership with the home's Pharmacist.

c) educate all registered nursing staff related to the licensee's Point Click Care e-MAR Policy Number 9.3 in a formal education session, and evaluate the 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 and treatment cream administration; and procedures specifically related to the use of the e-MARs transcribing orders, re-ordering of medication when a resident is returning from the hospital and the procedures related to Point Click Care e-MARs, e-TARs and medication management.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, r. 131 (1) by not ensuring that no drug was used by or administered to resident #007 and #012 unless the drug was prescribed for the resident.

Related to resident #007:

During an interview, resident #007 indicated the PSWs had been applying the identified treatment cream to sore knees in the morning and at bedtime since returning from the hospital on an identified date.

Review of resident #007's Medication Reconciliation Admission Order form identified that the Physician had not ordered the identified treatment cream upon resident #007's return from the hospital on the identified date.

During an interview, PSW #113 indicated applying the identified treatment cream to resident #007's legs on two identified dates following the residents return from hospital.

During an interview, RPN#114 indicated that resident #007 had an order for the identified treatment cream and review of resident #007's TAR identified that RPN #114 had documented the identified treatment cream had been administered on two occasions since the resident returned from the hospital.

According to Pharmacist #110 the identified treatment cream for resident #007 was entered into the e-TAR for resident #007's for identified area twice a day prior to transfer to hospital on an identified date. Pharmacist #110 indicated that when resident #007 returned from the hospital the identified treatment cream remained on the e-TAR despite not being ordered by the Physician.

Therefore, the identified treatment cream was being applied to resident #007's identified area and the treatment cream had not been prescribed by the Physician upon return from the hospital on an identified date.

Related to resident #012:

During an interview on an identified date, resident #012 indicated that a cream was being applied to an identified area when required. Resident #012 indicated the PSWs will apply the cream at night before going to bed and the cream is not applied every night, just when required to the area identified.

Review of resident #012's Physician order identified that the treatment cream was finished ten days prior to the resident indicating that the PSWs were still

applying the treatment cream.

During an interview, PSW #116 indicated that resident #012 had a treatment cream for an identified area and the cream was applied on two identified dates after the treatment cream was finished.

During an interview, RPN #117 indicated resident #012 had an order to apply the treatment cream identified and the treatment cream was given to the PSW to apply on an identified date after the medication was discontinued.

Review of resident #012's progress notes for on an identified date identified that RPN #114 had documented that resident #012's identified area was improving and the identified treatment cream was still needed.

Therefore, the identified treatment cream was being applied to resident #012's identified area and the treatment cream had been discontinued by the Physician on ten days prior.

The licensee failed to comply with O. Reg. 79/10, r. 131(2) by not ensuring that resident #007's drugs were administered to the resident in accordance with the directions for use as specified by the prescriber.
Resident #007 returned from the hospital on an identified date.

Review of resident #007's Medication Administration Record (MAR) on the day after the resident returned from the hospital identified that RPN #118 had documented the 0800 hour medication as not available.

During an interview, RPN #118 indicated that ten identified medications were not administered to resident #007 as prescribed on the identified date and the medication was not signed as administered due to the medication not being available.

Resident #007 had three identified medications that were ordered by the Physician for twice daily and was scheduled to be administered at 1600 hours.

During an interview with Inspector #601, RPN #118 indicated being informed by the night nurse that resident #007's medication had been ordered and would be arriving the morning resident did not receive the medication. RPN #118

indicated that on the identified date at approximately 1200 hours the ADOC informed RPN #118 that resident #007's medication had arrived from the Pharmacy. RPN #118 indicated that resident #007's medication remained in the ADOC's office until approximately 1300 hours while RPN #118 assisted other residents with their lunch meal. RPN #118 indicated that resident #007's 0800 hours medication were documented as not available because the medication arrived from the identified Pharmacy later in the day and the time frame exceeded the scheduled administration time as per the home's policy. RPN #118 also indicated not calling the Physician for direction about the medication not being available on the identified date and time as prescribed and using clinical judgment to not give the 0800 hour medication to resident #007 on the identified date.

Therefore, resident #007 did not receive ten identified medications on the identified date at 0800 hours as prescribed by the Physician.

Related to resident #007:

During an interview, resident #007 indicated that the PSWs have been applying a treatment cream twice a day since returning from the hospital six days prior.

Record review of resident #007's health care record indicated a Physician order to apply an identified treatment cream to a specific area twice a day when the resident returned from the hospital.

During an interview, Pharmacist #110 indicated the identified topical cream was entered into the e-MAR incorrectly and it would only prompt the nurse to sign for the identified topical cream once a day instead of twice daily as ordered by the Physician.

During an interview, PSW #119 indicated providing personal care to resident #007 on two evening shifts since the resident returned from the hospital. PSW #119 indicated that resident #007 does not have an order for a treatment cream since returning from the hospital.

During an interview, RPN #114 indicated that resident #007's Physician order was for an identified treatment cream to be applied to a specific area during the day shift only and that resident #007's identified treatment cream was not applied on an identified date four days following the resident's return from the

hospital on the evening shift.

Therefore, resident #007's identified treatment cream was not being applied to resident #007's identified area twice daily as prescribed by the Physician.

The non-compliance with O. Reg. 79/10, r. 131(1) and (2) order is being issued based on the fact that medication was not provided as prescribed and there was an absence of an effective monitoring process in place to ensure safe administration of medication and medicated treatment creams. Two residents were identified as receiving a medicated treatments creams not prescribed by the Physician and resident #007 was identified as not receiving medication and a medicated treatment cream as prescribed by the Physician. Therefore, there is a risk of harm and potential adverse side effects related to the medication incidents and ineffective monitoring to uncover medication errors. In addition, the compliance history of the licensee includes orders on December 23, 2015, O. Reg. 79/10, 131(2), October 30, 2015, O. Reg. 79/10, 131(1) and (2), non-compliance was also identified in the same areas, O.Reg.79/10, r. 131(1) on July 27, 2015, O. Reg. 79/10, r. 131(2) on March 13, 2014 and June 16, 2014. (601)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 29, 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_389601_0028, CO #003;

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 :

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

b) analyze the home's medication administration, including treatment creams for every resident to determine if there are medication incidents requiring evaluation and corrective action for the purpose of identifying and reducing medication incidents;

c) education of staff specifically in relation to the management of medication errors, and appropriate action to be taken in response to any medication error and take appropriate action in response to all medication incidents.

Grounds / Motifs :

1. The licensee formal monitoring process for medication incidents failed to identify a medication transcribing error for resident #013 and failed to identify medication incidents for resident #007 and #012.The licensee also failed to ensure 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 for resident #007 and #012.

During an interview, the Regional Clinical Manager indicated a formal medication monitoring process was put into place for all residents by generating a Physician's Orders Audit Report in PCC e-MAR system every twelve hours to monitor medication administration and identify medication errors.

During an interview, the ADOC indicated that on an identified date and time, RN #123 administered resident #013's identified medication prior to transcribing the order in the e-MAR system.

Review of the licensee's Point Click Care (PCC) e-Mar Policy Number 9.3 - Ordering New Prescriptions Using Point Click Care indicated the following: All new prescriber orders must be entered in Point Click Care to populate the e-MAR; this process may be completed by the nurse upon receipt of a new prescriber order.

The next day, RN #120 was reviewing the PCC e-MAR for resident #013 and noted the identified medication was required to be administered at 0830 hours. RN #120 contacted RN #123 because the RN who transcribed the order was not working and couldn't have entered the identified medication in PCC e-MAR. It was discovered that RN #123 had administered resident #013's identified medication on the day prior at 0830 hours and the administration of the medication had not been documented at that time.

During an interview, the ADOC indicated that RN #123 did not transcribe the order for resident #013's identified medication prior to administration and because the 0830 hours administration time had already past the PCC e-MAR system generated the identified medication to be given on the following day at 0830 hours.

Therefore, the licensee's formal monitoring process put in place did not identify a potential medication error that could have occurred on the identified date at 0830 hours. RN #123 did not enter the identified medication on PCC e-MAR upon receipt of a new prescribed order and the identified medication was not documented immediately after administration in the e-MAR on the day it was administered at 0830 hours as per the licensee's policies.

During an interview, the ADOC indicated not being aware that resident #007's identified treatment cream and resident #012's identified treatment cream were being applied without being prescribed by the Physician.

During an interview, the ADOC also indicated not being aware that resident #007 did not receive medication as prescribed by the Physician on an identified date and was not aware that resident #007's identified treatment cream prescribed by the Physician to be applied twice daily was not being applied as specified.

Therefore, resident #007 and #012's medication incidents were not identified by the formal monitoring process put into place by the licensee and the drug reaction was not documented, reviewed, analyzed and a corrective action was not taken as necessary to prevent re-occurrence.

The non-compliance with O. Reg. 79/10, 135(2) (a)(b)(c) order is being issued based on the fact that during the follow up inspection initiated on February 8, 2016 related to medication incidents identified that four medication incidents had occurred following the compliance date of January 31, 2016, despite a formal monitoring process being put into place by the licensee. Inspector #601 identified that there was a medication transcribing error for resident #013 that was discovered by the RN the following day. It was also identified that the formal monitoring process in place for medication incidents did not identify that resident #007, #012 treatment creams were administered without being prescribed by the Physician and that resident #007 did not receive the medications and treatment cream as prescribed by the Physician following the compliance date of January 31, 2016. Therefore, a written record was not kept for every medication incident involving resident #007 and #012, including potential adverse drug reactions were not documented, reviewed, analyzed and a corrective action was not taken as necessary. In addition, the compliance history of the licensee included an order issued on December 23, 2015 and a similar area on September 11, 2015 related to medication administration. (601)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 29, 2016

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

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 15th day of April, 2016

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