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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 31, 2019	2019_746692_0012	002739-19	Complaint

Licensee/Titulaire de permis

Rykka Care Centres LP
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

Hawthorne Place Care Centre
2045 Finch Avenue West NORTH YORK ON M3N 1M9

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

SHANNON RUSSELL (692)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 6-10 and May 13-17, 2019

The Following intake was inspected upon during this Complaint Inspection:
-One log related to a complaint related to a shortage of staff and the distribution of medication

A Critical Incident System inspection #2019_746692_0013 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Acting Director of Care (DOC), Associate Director of Care (ADOC), Clinical Consultant Pharmacist, Manager of Quality Improvement for a pharmacy, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions and resident to resident interactions, reviewed relevant health care records, complaint logs, as well as numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Medication
Sufficient Staffing

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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 :

1. The licensee has failed to ensure that drugs were administered to residents in

accordance with the directions for use as specified by the prescriber.

A complaint was submitted to the Director on an identified date, regarding the distribution of medications. The complainant indicated that some residents on an identified unit of the home were going without medications or were having to wait five to six hours later than when the medications were ordered to be administered, and that this was worrisome to them.

Inspector #692 reviewed the quarterly Physician's Medication Review Report for resident #001 for the month the complaint was submitted. The report indicated the resident was ordered to receive specified medications to be administered at specific times.

Inspector #692 reviewed the Medication Administration Audit Report for resident #001 for the selected month, which indicated they received the specified medication past the ordered time, as follows:
-administered almost four hours later on the first date;
-administered three and a half hours later on the second date;
-administered two hours later on the third date;
-administered two and a half hours later on the fourth date;
-administered over three hours later on the fifth date;
-administered over two hours later on the sixth date;
-administered almost three hours later on the seventh date;
-administered two and a half hours later on the eighth date; and
-administered one and a half hours later on the ninth date.

A further review of the report for resident #001, indicated that another specified medication that was ordered to be administered at three specific times was given past the ordered times, as follows:
-the second dose administered over four hours later on the first date;
-the initial dose administered over three and a half hours later, and the second dose was administered four hours later on the second date;
-the initial dose administered almost one and a half hours later, and the second dose administered three hours later on the third date;
-the last dose administered almost one and a half hours later on the fourth date;
-the initial dose administered almost three hours later, the second dose administered almost three hours later, and the last dose administered over one hour later on the fifth date;
-the initial dose administered two and a half hours later on the sixth date;

-the initial dose administered one and a half hours later on the seventh date;
-the last dose administered one and a half hours later on the eighth date;
-the initial dose administered over two hours later on the ninth date;
-the initial dose administered almost six hours later on the tenth date;
-the second dose administered almost one and a half hours later on the eleventh date;
-the initial dose administered two hours later on the twelfth date;
-the last dose administered five and a half hours later on the thirteenth date;
-the second dose administered three hours later on the fourteenth date;
-the second dose administered over one hour later, and the last dose administered over one hour later on the fifteenth date; and
-the second dose administered over three hours later, and the last dose administered at over two and a half hours later on the sixteenth date.

A review of the policy titled, "Medication Pass", last revised October 1, 2018, identified that the nurse was to observe the eight rights of medication administration, including the: right resident, right medication/drug, right dose/amount, right time, right route, right reason, right site and right frequency.

Inspector #692 reviewed policy titled, "Medication Administration", last reviewed June 11, 2018, which indicated all medications were to be administered by the registered staff as per the physicians frequency ordered and document in the residents electronic Medication Administration Record (eMAR). A further review of the policy, indicated that all medications administered must be signed off as given by the registered staff as soon as the medications had been administered. If the resident missed a regular scheduled dose at the prescribed time, the registered staff must make an electronic progress note indicating the rationale for the change, the action completed, and document the appropriate code for the change in administration on the eMAR.

Inspector #692 reviewed resident #001's health care records and electronic progress notes in Point Click Care (PCC) for the month reviewed, and was unable to locate any documentation indicating there was a change with the administration of resident #001's medications for the indicated dates. A review of the resident's eMAR, indicated that the medications were administered to resident #001 as identified by a check mark and included the registered staff initials who administered the medication.

In an interview with Registered Practical Nurse (RPN) #143, they identified to Inspector #692 that registered staff were to follow the eight rights of medication administration when administering medications to residents. RPN #143 identified that they sign the

residents' eMAR at the time of administering the medications to them, which indicated that the medication was given at that time. The RPN further identified that if they administered medications to residents at different times than when the physician ordered them to be administered, registered staff were to document a progress note. After reviewing resident #001's progress notes for the dates reviewed, RPN #143 confirmed that there was no progress notes dated for the times that they administered medications to resident #001 past the prescribers order scheduled time of administration.

During an interview with Registered Nurse (RN) #142, they confirmed that resident #001 was administered their medications late on the reviewed dates, and was unable to provide rationale for this occurring.

Inspector #692 interviewed Quality Improvement Manager #139, who identified that registered staff were to administer medications at the time the prescriber ordered and if there was a change the registered staff were to document the reason for the change. They further indicated if medications were not administered at the time the prescriber ordered, there could be adverse reactions to the resident. Quality Manager #139 provided an adverse reaction example specific to the medications resident #001 received later than prescribed.

In an interview with Associate Director of Care (ADOC) #102, they identified that if a resident received medications at times other than the prescribed times, registered staff were to complete progress notes, documenting the change, the reason for the change and what action was taken. Together, the Inspector with ADOC#102 reviewed the Medication Administration Audit Report and electronic progress notes for resident #001 for the dates reviewed, and did not locate any documentation indicating rationale as to why resident #001 received their medications past their scheduled time of administration. ADOC #102 confirmed that resident #001 received their medications later than the prescribed time.

The Acting Director of Care (DOC) indicated during an interview with Inspector #692, that it was the expectation that the residents received their medications at the prescribed time, which was one of the eight rights for medication administration. The Acting DOC confirmed that resident #001 did not receive their medications as per the physician's order, and it was the expectation that they should have.

2. Inspector #692 reviewed the quarterly Physician's Medication Review Report for resident #005 for the month the complaint was submitted. The report indicated the

resident was ordered to receive a specified medication to be administered at an identified time.

In a review of the Medication Administration Audit Report for resident #005 for the selected month, which indicated the resident received the specified medication past the ordered time, as follows:
-administered almost three hours later on the first date;
-administered over three hours later on the second date;
-administered almost three hours later on the third date;
-administered almost four hours later on the fourth date;
-administered over four hours later on the fifth date;
-administered almost four hours later on the sixth date;
-administered over four and a half hours later on the seventh date;
-administered almost four hours later on the eighth date; and
-administered almost three hours later on the ninth date.

Inspector #692 interviewed resident #005, who indicated they have received their scheduled medications hours after they were supposed to be administered them. Resident #005 was unable to recall the exact number of times this had occurred, yet was able to confirm it had occurred on multiple days.

Inspector #692 reviewed resident #005's electronic health care records, including progress notes, eMAR and Point of Care (POC) documentation in PCC for the reviewed month. The Inspector was unable to locate any documentation indicating that there were any changes to the administration of the medication. A review of the resident's eMAR for the above mentioned dates, indicated that registered staff had administered the medications to resident #005 at the time documented. There were not any entries that indicated that the medications for resident #005 were held or administered at a later time.

In separate interviews with RPN #143 and RN #142, they identified to Inspector #692 that registered staff were to follow the eight rights of medication administration, which included: the right time, and were to sign eMAR as soon as they had administered the medications to the resident. They both confirmed that if there was a change to the scheduled time of administrating a medication the registered staff were to document the rationale, including the action taken, and if there was not a progress note, then the time of the medication being administered to the resident was the time indicated on the eMAR. RPN #143 confirmed that they administered the specified medication later than the ordered time to resident #005, and could not indicate the reason for doing so.

Inspector #692 interviewed Quality Improvement Manager #139, who identified that registered staff were to administer medications at the time the prescriber ordered and if there was a change the registered staff were to document the reason for the change. They further indicated that if resident #005 had received the specified medication past the time the prescriber had ordered, there could be adverse reactions to the resident. Quality Manager #139 provided an adverse reaction example specific to the medications resident #005 received later than prescribed.

In separate interviews with ADOC #102 and Acting DOC, they identified that if a resident receives medications at times other than the prescribed times registered staff were to complete progress notes, documenting the change, the reason for the change and what action was taken. Together, the Inspector with ADOC#102 reviewed resident #005's electronic progress notes and did not locate any documentation indicating rationale as to why resident #005 received their medications late. The Acting DOC and ADOC #102 both confirmed that it was the expectation that the resident received their medications at the prescribed time, and that resident #005 did not.

3. Inspector #692 reviewed the quarterly Physician's Medication Review Report for resident #019 for the selected month. The report indicated the resident was ordered to receive specified medications to be administered at identified times.

Inspector #692 reviewed the Medication Administration Audit Report for resident #019 for the month reviewed, which indicated the resident received the specified medications past the ordered times, as follows:
-administered almost two hours later on the first date;
-administered almost two hours later on the second date;
-administered one and a half hours later on the third date;
-administered almost three hours later on the fourth date;
-administered almost two hours later on the fifth date.

Inspector #692 interviewed resident #019. They indicated they have on occasions received their scheduled medications hours after they were supposed to be administered them, yet was unable to recall when this had occurred.

Inspector #692 reviewed resident #019's electronic health care records, including progress notes, eMAR and POC documentation in PCC for the selected month. The Inspector was unable to locate any documentation indicating that there were any

changes to the administration of the medication on those dates. A review of the resident's eMAR for the above mentioned dates, indicated that the medications were administered to resident #019 at the times indicated.

In an interview with Inspector #692, RPN #130 identified that registered staff were to follow the eight rights of medication administration, and they were to sign the eMAR as soon as they had administered the medications to the resident. RPN #130 confirmed that if there was a change to the scheduled time of administering a medication the registered staff were to document the rationale, including the action taken, and if there was no progress note, then the time of administration was the time on the eMAR. Together, the Inspector with the RPN reviewed the documentation for resident #019 and RPN #130 confirmed resident #019 was administered their medications past the prescribed order on the dates reviewed.

Inspector #692 interviewed Quality Improvement Manager #139, who identified that registered staff were to administer medications at the time the prescriber ordered and if there was a change the registered staff were to document the reason for the change. They further indicated if medications were not administered at the time the prescriber ordered, there could be adverse reactions to the resident. Quality Manager #139 provided an adverse reaction example specific to the medications resident #019 received later than prescribed.

In an interview with Inspector #692, Acting DOC identified that if a resident received medications at times other than the prescribed times registered staff were to complete progress notes, documenting the change, the reason for the change and what action was taken. Together, the Inspector with the Acting DOC reviewed resident#019's electronic progress notes and did not locate any documentation indicating rationale as to why resident #019 received their medications past the scheduled administration time. The Acting DOC confirmed that it was the expectation that the resident received their medications at the prescribed time, and that resident #019 did not.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 31st day of May, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHANNON RUSSELL (692)
Inspection No. / No de l'inspection :	2019_746692_0012
Log No. / No de registre :	002739-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 31, 2019
Licensee / Titulaire de permis :	Rykka Care Centres LP 3760 14th Avenue, Suite 402, MARKHAM, ON, L3R-3T7
LTC Home / Foyer de SLD :	Hawthorne Place Care Centre 2045 Finch Avenue West, NORTH YORK, ON, M3N-1M9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Charlotte Altenburg

To Rykka Care Centres LP, you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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 must be compliant with r. 131. (2) of the Ontario Regulation 79/10.

Specifically the licensee must:
a) Ensure that medications are administered to residents #001, #005, #019, and any other resident, at their prescribed time;
b) Conduct and document scheduled audits of resident's electronic Medication Administration Record (eMAR); and
c) Maintain a record of the results of the audit and the actions taken to address the concerns.

Grounds / Motifs :

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

A complaint was submitted to the Director on an identified date, regarding the distribution of medications. The complainant indicated that some residents on an identified unit of the home were going without medications or were having to wait five to six hours later than when the medications were ordered to be administered, and that this was worrisome to them.

Inspector #692 reviewed the quarterly Physician's Medication Review Report for resident #001 for the month the complaint was submitted. The report indicated the resident was ordered to receive specified medications to be administered at specific times.

Inspector #692 reviewed the Medication Administration Audit Report for resident #001 for the selected month, which indicated they received the specified

medication past the ordered time, as follows:
-administered almost four hours later on the first date;
-administered three and a half hours later on the second date;
-administered two hours later on the third date;
-administered two and a half hours later on the fourth date;
-administered over three hours later on the fifth date;
-administered over two hours later on the sixth date;
-administered almost three hours later on the seventh date;
-administered two and a half hours later on the eighth date; and
-administered one and a half hours later on the ninth date.

A further review of the report for resident #001, indicated that another specified medication that was ordered to be administered at three specific times was given past the ordered times, as follows:
-the second dose administered over four hours later on the first date;
-the initial dose administered over three and a half hours later, and the second dose was administered four hours later on the second date;
-the initial dose administered almost one and a half hours later, and the second dose administered three hours later on the third date;
-the last dose administered almost one and a half hours later on the fourth date;
-the initial dose administered almost three hours later, the second dose administered almost three hours later, and the last dose administered over one hour later on the fifth date;
-the initial dose administered two and a half hours later on the sixth date;
-the initial dose administered one and a half hours later on the seventh date;
-the last dose administered one and a half hours later on the eighth date;
-the initial dose administered over two hours later on the ninth date;
-the initial dose administered almost six hours later on the tenth date;
-the second dose administered almost one and a half hours later on the eleventh date;
-the initial dose administered two hours later on the twelfth date;
-the last dose administered five and a half hours later on the thirteenth date;
-the second dose administered three hours later on the fourteenth date;
-the second dose administered over one hour later, and the last dose administered over one hour later on the fifteenth date; and
-the second dose administered over three hours later, and the last dose administered at over two and a half hours later on the sixteenth date.

A review of the policy titled, "Medication Pass", last revised October 1, 2018, identified that the nurse was to observe the eight rights of medication administration, including the: right resident, right medication/drug, right dose/amount, right time, right route, right reason, right site and right frequency.

Inspector #692 reviewed policy titled, "Medication Administration", last reviewed June 11, 2018, which indicated all medications were to be administered by the registered staff as per the physicians frequency ordered and document in the residents electronic Medication Administration Record (eMAR). A further review of the policy, indicated that all medications administered must be signed off as given by the registered staff as soon as the medications had been administered. If the resident missed a regular scheduled dose at the prescribed time, the registered staff must make an electronic progress note indicating the rationale for the change, the action completed, and document the appropriate code for the change in administration on the eMAR.

Inspector #692 reviewed resident #001's health care records and electronic progress notes in Point Click Care (PCC) for the month reviewed, and was unable to locate any documentation indicating there was a change with the administration of resident #001's medications for the indicated dates. A review of the resident's eMAR, indicated that the medications were administered to resident #001 as identified by a check mark and included the registered staff initials who administered the medication.

In an interview with Registered Practical Nurse (RPN) #143, they identified to Inspector #692 that registered staff were to follow the eight rights of medication administration when administering medications to residents. RPN #143 identified that they sign the residents' eMAR at the time of administering the medications to them, which indicated that the medication was given at that time. The RPN further identified that if they administered medications to residents at different times than when the physician ordered them to be administered, registered staff were to document a progress note. After reviewing resident #001's progress notes for the dates reviewed, RPN #143 confirmed that there was no progress notes dated for the times that they administered medications to resident #001 past the prescribers order scheduled time of administration.

During an interview with Registered Nurse (RN) #142, they confirmed that resident #001 was administered their medications late on the reviewed dates, and was unable to provide rationale for this occurring.

Inspector #692 interviewed Quality Improvement Manager #139, who identified that registered staff were to administer medications at the time the prescriber ordered and if there was a change the registered staff were to document the reason for the change. They further indicated if medications were not administered at the time the prescriber ordered, there could be adverse reactions to the resident. Quality Manager #139 provided an adverse reaction example specific to the medications resident #001 received later than prescribed.

In an interview with Associate Director of Care (ADOC) #102, they identified that if a resident received medications at times other than the prescribed times, registered staff were to complete progress notes, documenting the change, the reason for the change and what action was taken. Together, the Inspector with ADOC #102 reviewed the Medication Administration Audit Report and electronic progress notes for resident #001 for the dates reviewed, and did not locate any documentation indicating rationale as to why resident #001 received their medications past their scheduled time of administration. ADOC #102 confirmed that resident #001 received their medications later than the prescribed time.

The Acting Director of Care (DOC) indicated during an interview with Inspector #692, that it was the expectation that the residents received their medications at the prescribed time, which was one of the eight rights for medication administration. The Acting DOC confirmed that resident #001 did not receive their medications as per the physician's order, and it was the expectation that they should have.
(692)

2. Inspector #692 reviewed the quarterly Physician's Medication Review Report for resident #005 for the month the complaint was submitted. The report indicated the resident was ordered to receive a specified medication to be administered at an identified time.

In a review of the Medication Administration Audit Report for resident #005 for

the selected month, which indicated the resident received the specified medication past the ordered time, as follows:
-administered almost three hours later on the first date;
-administered over three hours later on the second date;
-administered almost three hours later on the third date;
-administered almost four hours later on the fourth date;
-administered over four hours later on the fifth date;
-administered almost four hours later on the sixth date;
-administered over four and a half hours later on the seventh date;
-administered almost four hours later on the eighth date; and
-administered almost three hours later on the ninth date.

Inspector #692 interviewed resident #005, who indicated they have received their scheduled medications hours after they were supposed to be administered them. Resident #005 was unable to recall the exact number of times this had occurred, yet was able to confirm it had occurred on multiple days.

Inspector #692 reviewed resident #005's electronic health care records, including progress notes, eMAR and Point of Care (POC) documentation in PCC for the reviewed month. The Inspector was unable to locate any documentation indicating that there were any changes to the administration of the medication. A review of the resident's eMAR for the above mentioned dates, indicated that registered staff had administered the medications to resident #005 at the time documented. There were not any entries that indicated that the medications for resident #005 were held or administered at a later time.

In separate interviews with RPN #143 and RN #142, they identified to Inspector #692 that registered staff were to follow the eight rights of medication administration, which included: the right time, and were to sign eMAR as soon as they had administered the medications to the resident. They both confirmed that if there was a change to the scheduled time of administrating a medication the registered staff were to document the rationale, including the action taken, and if there was not a progress note, then the time of the medication being administered to the resident was the time indicated on the eMAR. RPN #143 confirmed that they administered the specified medication later than the ordered time to resident #005, and could not indicate the reason for doing so.

Inspector #692 interviewed Quality Improvement Manager #139, who identified that registered staff were to administer medications at the time the prescriber ordered and if there was a change the registered staff were to document the reason for the change. They further indicated that if resident #005 had received the specified medication past the time the prescriber had ordered, there could be adverse reactions to the resident. Quality Manager #139 provided an adverse reaction example specific to the medications resident #005 received later than prescribed.

In separate interviews with ADOC #102 and Acting DOC, they identified that if a resident receives medications at times other than the prescribed times registered staff were to complete progress notes, documenting the change, the reason for the change and what action was taken. Together, the Inspector with ADOC #102 reviewed resident #005's electronic progress notes and did not locate any documentation indicating rationale as to why resident #005 received their medications late. The Acting DOC and ADOC #102 both confirmed that it was the expectation that the resident received their medications at the prescribed time, and that resident #005 did not. (692)

3. Inspector #692 reviewed the quarterly Physician's Medication Review Report for resident #019 for the selected month. The report indicated the resident was ordered to receive specified medications to be administered at identified times.

Inspector #692 reviewed the Medication Administration Audit Report for resident #019 for the month reviewed, which indicated the resident received the specified medications past the ordered times, as follows:
-administered almost two hours later on the first date;
-administered almost two hours later on the second date;
-administered one and a half hours later on the third date;
-administered almost three hours later on the fourth date;
-administered almost two hours later on the fifth date.

Inspector #692 interviewed resident #019. They indicated they have on occasions received their scheduled medications hours after they were supposed to be administered them, yet was unable to recall when this had occurred.

Inspector #692 reviewed resident #019's electronic health care records,

including progress notes, eMAR and POC documentation in PCC for the selected month. The Inspector was unable to locate any documentation indicating that there were any changes to the administration of the medication on those dates. A review of the resident's eMAR for the above mentioned dates, indicated that the medications were administered to resident #019 at the times indicated.

In an interview with Inspector #692, RPN #130 identified that registered staff were to follow the eight rights of medication administration, and they were to sign the eMAR as soon as they had administered the medications to the resident. RPN #130 confirmed that if there was a change to the scheduled time of administering a medication the registered staff were to document the rationale, including the action taken, and if there was no progress note, then the time of administration was the time on the eMAR. Together, the Inspector with the RPN reviewed the documentation for resident #019 and RPN #130 confirmed resident #019 was administered their medications past the prescribed order on the dates reviewed.

Inspector #692 interviewed Quality Improvement Manager #139, who identified that registered staff were to administer medications at the time the prescriber ordered and if there was a change the registered staff were to document the reason for the change. They further indicated if medications were not administered at the time the prescriber ordered, there could be adverse reactions to the resident. Quality Manager #139 provided an adverse reaction example specific to the medications resident #019 received later than prescribed.

In an interview with Inspector #692, Acting DOC identified that if a resident received medications at times other than the prescribed times registered staff were to complete progress notes, documenting the change, the reason for the change and what action was taken. Together, the Inspector with the Acting DOC reviewed resident #019's electronic progress notes and did not locate any documentation indicating rationale as to why resident #019 received their medications past the scheduled administration time. The Acting DOC confirmed that it was the expectation that the resident received their medications at the prescribed time, and that resident #019 did not.

The severity of this issue was determined to be a level two, as there was minimal harm/risk of harm. The scope of the issue was a level three, as the issue was widespread. The home had a level three compliance history with one or more related non-compliance in the last 36 months with this section of the Ontario Regulation 79/10 that included:
-Voluntary Plan of Correction (VPC) issued December 13, 2018, (2018_642698_0006); and
-Compliance Order (CO) issued August 4, 2017, (2017_595604_0011).

(692)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 16, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 31st day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Shannon Russell

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