Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: October 5, 2023
Inspection Number: 2023-1425-0004
Inspection Type: Complaint Critical Incident
Licensee: Hellenic Home for the Aged Inc.
Long Term Care Home and City: Hellenic Home - Scarborough, Scarborough

Lead Inspector	**Inspector Digital Signature**
Nicole Ranger (189)	Nicole S Ranger Digitally signed by Nicole S Ranger Date: 2023.10.25 10:47:38 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 22, 26, 27, 28, 2023

The following intake(s) were inspected:

- Intake: #00095147 - Critical Incident System (CIS) #2941-000024-23 related to medication management
- Intake: #00095710 - Complaint related to prevention of abuse and neglect, medication management

The following **Inspection Protocols** were used during this inspection:

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that the provision of care set out in resident #001's plan of care was documented.

Rationale and Summary

A resident was administered multiple high-risk medications in error by Agency Registered Practical Nurse (RPN) #101. These medications were not prescribed for the resident. As a result, the resident experienced several severe symptoms which led them to be transferred to the hospital for further assessment and treatment.

Review of resident #001's progress notes identified no documentation of the medication incident that occurred. There were no documentation of vital signs taken, when there was a change to the resident's condition, or that the resident received medications in error.

Registered Nurse (RN) # 104 stated that they assessed the resident with vital signs and informed the physician of the medication error, however acknowledged that they did not document their assessment, nor document the physician notification. Agency RPN #101, who had given the medications in error, acknowledged that they did not document the medication incident in the progress notes.

The Director of Care (DOC) and Quality Improvement and Education Manager acknowledged that the registered staff did not document the details of the medication incident in the resident's progress notes.

There was risk of harm to the resident when the medication incident and provision of care was not documented.

Sources: Resident #001 progress notes, home's investigation file, interview with agency RPN #101, RN #104, Director of Care #103 and Quality Improvement and Education Manager # 105**.**

ii) The licensee has failed to ensure that the provision of care set out in resident #001's plan of care was documented.

Rationale and Summary

Resident #002, who had an intact cognitive function, reported that they did not receive their medications on an identified date. RN #104 reported that they took resident #002's medications from the next day mediation blister pack, along with a narcotic, and administered the medications to the resident.

Resident #002 Medication Administrator Record (MAR) and progress notes showed no documentation concerning the medication errors, or that the next day medication was administered to the resident by RN #104. RN #104 acknowledged that they did not document the administration of the medications in the resident's progress notes or MAR.

The DOC and Quality Improvement and Education Manager acknowledged that the registered staff did not document the administration of medication in the progress notes or MAR as required.

There was risk of harm to the resident when the medication administration and provision of care was not documented.

Sources: Resident #001 progress notes, home's investigation notes, interview with agency RPN #101, RN #104, Director of Care #103 and Quality Improvement and Education Manager # 105.

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WRITTEN NOTIFICATION: MONITORED DOSAGE SYSTEM

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 134 (2)

The licensee has failed to comply with their medication management policy related to wastage of narcotics.

Rationale and Summary
In accordance with O. Reg 246/22, s. 11. (1)(b), the licensee was required to ensure the written policies and protocols developed for the medication management system to ensure the accurate acquisition, dispensing, and administration was complied with.

Specifically, registered staff did not comply with the licensee's policy for wasted narcotics, that for

wastage of narcotics, it must be destroyed and disposed in the presence of two nurses. Both nurses must sign on the Narcotic Administration and Controlled Drug Tracking Sheet.

Review of resident #002's Narcotic Administration and Controlled Drug Tracking Sheet identified that on an identified date, Agency RPN #101 wasted a narcotic without a second nurse's signature for witnessing the wastage.

The DOC and Quality Improvement and Education Manager stated that two nurses are required to observe and sign for narcotic wastage, and acknowledged that staff did not follow the home's policy for a second nurse's requirement for narcotic wastage.

Sources: Resident #002 Narcotic Administration and Controlled Drug Tracking Sheet, home's investigation notes, Medication General Policy revised June 2023, interview with agency RPN #101, DOC, Quality Improvement and Education Manager, and other staff

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ii) The licensee has failed to comply with the medication management policy related to insulin administration.

Rationale and Summary

In accordance with O. Reg 246/22, s. 11. (1)(b), the licensee was required to ensure the written policies and protocols developed for the medication management system to ensure the accurate acquisition, dispensing, and administration was complied with.

Specifically, registered staff did not comply with the licensee's policy for insulin administration, which requires two registered nurses signature to verify the insulin administration to a resident.

Resident #001 was administered multiple high-risk medications by Agency RPN #101. These medications were prescribed for resident #002.

Review of resident #002's MAR identify the resident receives insulin. Agency RPN #101 reported that they administered insulin to resident #001 in a medication error. The MAR noted a missing second nurses signature for the insulin administration.

The DOC and Quality Improvement and Education Manager stated that two nurses are required to review and check for insulin administration, and acknowledged that staff did not follow the home's policy for a second nurse sign for the insulin administration.

There was risk of harm to the resident when the insulin administration review procedure was not followed.

Sources: Review of resident #002 Medication Administration Record (MAR) and Medication Administration History, Insulin Administration – Double Check Verification for Accuracy policy, home's investigation notes, interview with agency RPN #101, DOC #103, Quality Improvement and Education Manager, and other staff.

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WRITTEN NOTIFICATION: MEDICAITON INCIDENTS AND ADVERSE DRUG REACTIONS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (2) (b)

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction, corrective action is taken as necessary.

Rationale and Summary

Resident #001 was administered multiple high-risk medications in error by Agency RPN #101. These medications were not prescribed for resident #001. As a result, the resident's symptoms required transferring to the hospital for further assessment and treatment.

The home identified on the CIS report as part of their long term action plan to correct the situation and prevent reoccurrence to add residents' photos to the individual residents' medications drawers.

On an identified date, the inspector observed two medication carts and noted no residents' photos on the medication drawers. The inspector inquired if registered staff had any recent education on medication management and administration and RPN #106 reported they did not receive any recent training after the medication incident.

The Quality Improvement and Education Manager and DOC stated they were in the process of placing residents' photos on the medication drawers in consultation with the pharmacy. The Quality Improvement and Education Manager stated their plan was to provide registered staff in-service training on medication management and administration, however this has not occurred at the time of the inspection.

There was no documented evidence to show corrective action was taken to correct the situation and to prevent reoccurrence.

Sources: Observation of medication carts, CIS #2941-000024-23, home's investigation notes, interview with RPN #106, DOC and Quality Improvement and Education Manager.

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COMPLIANCE ORDER CO #001 ADMINISTRATION OF DRUGS

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Re-educate agency and registered nursing staff working at the home related to the current College of Nurses of Ontario (CNO) Practice Standard for Medication, as well as review the home's Medication Administration policy, with a focus on identifying the resident/client as reflected in the practice standard.
2. Maintain a record of the training completed, including but not limited to, date of training and staff who conducted the training, staff attendance, and the materials reviewed.

Grounds

The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Rationale and Summary

A resident was administered multiple high-risk medications in error by Agency Registered Practical Nurse (RPN) #101. These medications were not prescribed for the resident. As a result, the resident experienced several severe symptoms which led them to be transferred to the hospital for further assessment and treatment.

Agency RPN #101 stated that they asked the Resident Care Coordinator (RCC) #102 to assist with identifying the resident, and by misinterpretation, the wrong resident was identified. Agency RPN #101

confirmed they did not verify resident #001's identity to ensure that the medications were being administered to the correct resident.

The Director of Care (DOC) and Quality Improvement and Education Manager acknowledged that the RPN did not verify that the identity of the resident who was receiving the medication and that resident #001 received medications that were not prescribed for them.

There was actual harm to resident #001 when they received medication which was not prescribed for them.

Sources: resident #001 and resident #002's clinical record, CIS #2941-000024-23, home's investigation notes, and interview with agency RPN #101 RCC #102, DOC #103 and other staff

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This order must be complied with by

November 10, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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