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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 8, 2019	2018_605213_0027	023429-17, 003011-18, 007154-18, 008211-18, 014088-18, 014805-18, 015245-18, 024613-18, 027597-18	Complaint

Licensee/Titulaire de permis

peopleCare Inc.
735 Bridge Street West WATERLOO ON N2V 2H1

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

peopleCare Oakcrossing London
1242 Oakcrossing Road LONDON ON N6H 0G2

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

RHONDA KUKOLY (213), CHRISTINA LEGOUFFE (730), DONNA TIERNEY (569), KRISTEN MURRAY (731), NATALIE MORONEY (610)

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): December 10, 11, 12, 14, 17, 18, 19, 20, 2018.

This inspection was completed related to the following critical incidents:
Log #023429-17 Infoline #IL-53382-LO related to plan of care concerns.
Log #003011-18 Critical Incident #2980-000003-18 related to alleged staff to resident physical abuse.
Log #007154-18 Critical Incident #2980-000014-18 related to alleged staff to resident physical abuse.
Log #008211-18 Infoline #IL-56593-LO and #IL-56609-LO related to care concerns.
Log #014088-18 Infoline #IL-57460-LO related to care concerns.
Log #014805-18 Critical Incident #2980-000024-18 related to a fall.
Log #015245-18 Critical Incident #2980-000025-18 related to alleged staff to resident neglect.
Log #024613-18 Related to medication concerns.
Log #027597-18 Infoline #IL60928-LO related to care concerns.

The following complaints were also reviewed while in the home:
Log #005227-18 related to medication concerns.
Log #006796-18 Infoline #IL-56331-LO related to plan of care concerns.
Log #026837-18 Infoline #IL-60632-LO related to pharmacy provider concerns.
Log #028169-17 Infoline #IL-54474-LO and #IL-55275-LO related to care concerns.
Log #021530-18 Infoline #IL-59069-LO related to plan of care concerns.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Administrator, the Director of Care, the Assistant Director of Care, a Physician, a Pharmacist and Pharmacy Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, residents and family members.

The Inspectors also made observations and reviewed health records, policies and procedures, internal investigation records, employee files, education records, and other relevant documentation.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation

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

- **2 WN(s)**
- **0 VPC(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not neglected by the licensee or

staff.

The Ministry of Health and Long-Term Care received a complaint related to the death of a resident and nursing care in the home at the time of the resident's death.

A record review of the health records for a resident, internal investigation records, policies and procedures, employee files, education records and other documentation was completed. Interviews were conducted with three registered nursing staff members who were on shift on the day that the identified resident passed away as well as the resident’s family member, the resident's physician, the Assistant Director of Nursing, the Administrator and the Executive Director.

On an identified date, a resident was found to be physically uncomfortable with specific problematic symptoms.

One registered nursing staff member assessed the resident, ruled out some specific problems, but suspected one specific problem. They contacted the charge nurse on their shift and comfort measures were provided, but the nurse was not able to complete the desired diagnostic test as the machine was left unplugged and was not charged.

The registered nursing staff member asked the family if they wanted the resident sent to hospital and the family declined.

The registered nursing staff member reported the resident's symptoms, actions taken and the need for the test to be done, to the oncoming registered nursing staff member.

The resident had advanced care wishes to not be sent to hospital. The family had requested to stay with the resident in their room while the resident was uncomfortable, this request was denied by the home. The family was told they were allowed to stay in a lounge and they left the home.

Four hours later, the next registered nursing staff member found the resident in acute distress and discomfort, completed the diagnostic test, found it to be problematic, and called the family to ask to send the resident to hospital. The family asked the registered nursing staff member to perform the nursing procedure and to call the physician. The registered nursing staff member told the family they were not comfortable performing the nursing procedure and that they could not call the physician at that time.

The registered nursing staff member was not comfortable completing a nursing procedure that would have likely improved or alleviated the problem and did not contact the charge nurse in the building or the resident's physician for advice or assistance.

The resident further rapidly declined and the registered nursing staff member called the family again who agreed to send the resident to hospital and then called for an ambulance to come.

The resident passed away when being transferred on to the ambulance stretcher.

The charge nurse was called after the ambulance was called and arrived on the unit after the resident had already passed away and the physician was called after the resident had passed away.

Both the registered nursing staff member and the charge nurse felt that the most important action to take was to ask the family and send the resident to hospital, not to call the charge nurse or the doctor for advice, not for the charge nurse to assess the resident, or to perform a nursing procedure that would likely have alleviated the identified problem for the resident.

The resident passed away within hours of a sudden decline as a result of the originally suspected problem, in distress.

The physician thought that the registered nursing staff member had pronounced the resident deceased.

The registered nursing staff member thought that the charge nurse had pronounced the resident deceased.

The charge nurse thought that the physician had pronounced the resident deceased.

The registered nursing staff member and charge nurse felt it was an unexpected death.

The physician felt it was an expected death, but sooner than expected.

There was no documentation of the pronouncement of death.

The physician felt that the nursing procedure that the registered nursing staff member

had been uncomfortable performing may have prevented the problem from worsening and prevented death at that time, and that the resident suffered needlessly as a result. The physician also felt that a nurse in long-term care should have been able and willing to perform the nursing procedure and that the resident's family should have been permitted to stay with the resident.

The Administrator said that the registered nursing staff member should have called the charge nurse and the physician when the resident was found to be in distress and the resident should have had the nursing procedure performed that would have likely improved or alleviated the original problem.

The coroner and the Ministry of Health and Long-Term Care were not notified of an unexpected death or neglect of the resident's needs.

The College of Nurses of Ontario was not notified of the situation involving the resident and the registered nursing staff member.

No action was taken by the home related to the diagnostic test machine being unusable and uncharged.

No education was provided to the registered nursing staff member or charge nurse related to the nursing procedure that would have likely improved or alleviated the problem or documentation of pronouncement of death.

The licensee has failed to ensure that a resident was not neglected by the licensee or staff when the resident's need for assessment and a nursing procedure was not met and the resident passed away in acute discomfort. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 specified by the prescriber.

A) The Ministry of Health and Long-Term Care received complaint related to medication administration incidents.

The home's internal investigation notes showed that there were three registered nursing staff members that did not administer an identified medication to a resident.

A review of the home's Medication Incidents documentation showed that that on four identified dates, an identified medication that was to be administered was found in the original packaging, and had not been administered and it was unclear if the previous dose was administered instead. Further review of the medication incident showed that the dosage on the packaging used one particular dosing term and the Electronic Administration Record (eMAR) used a different dosing term. It also said that the new dose of medication was unavailable until med delivery in the evening; however, it was charted as administered. Staff were unable to pull from OMNIcell as it did not have the correct dosage available.

A review of the medication administration audit report and physician's orders for a seven day period of time showed that one of the resident's physicians made changes to the order of an identified medication and the other had not approved it and ordered diagnostic testing. It also showed that on the three previous days, the medication had been documented as on hold. There were no orders to put the identified medication on hold. In addition, it showed that two medications were administered at the same time per the administration documentation and not 30 minutes apart as per the physician's orders prescribed.

The Pharmacy Manager told the Inspector that they also did not have an order to place the identified medication on hold. The resident's Power of Attorney (POA) had been

contacted for approval of cost for the medication and that they were waiting for the approval of the medication order and the approval was obtained. The Manager said the eMAR orders were completed by the pharmacy. The Pharmacy Manager stated that if they had been the pharmacist on, they would have notified the home that they did not have the medication, would have directed the nurse to use a liquid form and would have completed the conversion for the correct dosage; however, this change was not communicated by the pharmacy and the nursing staff did not receive any direction.

The medication incident details also stated physician was made aware of medication error. No immediate interventions were required and to continue with weekly diagnostic testing.

The day that the medication incident was discovered, a diagnostic alert was received indicating that an identified test level was abnormal. The registered nurse (RN) was notified and the physician called as well. The physician ordered a stat dose of the medication that had not been administered. Pharmacy was called and informed. The resident's POA was notified regarding abnormal diagnostic level and stat medication order.

The Director of Care (DOC) said that they thought the medication incidents occurred only on four days, and was not aware of the medication not given as prescribed for the three previous days. The DOC further stated that they felt staff might have pulled the two medications at the same time however the administration records of the two medications show they were not given as prescribed which was to be 30 minutes apart.

B) Another resident was to receive an identified medication on a specified date and time. A review of the documentation for Medication Incident's showed that this resident did not receive that medication as it was not available in the OMNIcell. The medication incident report shows that the nurse called the pharmacy to advise them the medication was not available and was advised to split a higher dose tablet into two halves. The dose was not provided at all.

The action plan was that pharmacy would make sure adequate medication was stocked properly before weekends and an action plan would be made for home representative to inform pharmacy if more stock was needed for a certain dose. The medication incident further showed that one nurse had also called the pharmacy earlier that day but was unable to reach the pharmacy.

The DOC stated that the pharmacy stocked three times a week, which had been a change, as they used to stock medication five days a week.

The Pharmacy Manager stated that they were a 24 hour pharmacy and they would send medication by a taxi if required to ensure medication was being administered as prescribed.

One registered nursing staff member said that they often have to dispense medication from the OMNIcell as they did not have the correct dosage available for administration. They also shared that on the day of the interview with the Inspector, they did not have the correct dosage for a resident as prescribed and needed to pull from two different home areas to get the correct dosage of medication that was a routine medication.

The Administrator stated it was the home's expectation that medications were being administered as prescribed and that staff should not be dispensing medication to ensure that residents were receiving the correct dosage of medication.

C) Another resident was to receive an identified medication twice a day. Medication Incident's documentation showed that this resident was not administered this medication for two days.

The licensee failed to ensure that drugs were administered to three residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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*

Issued on this 10th day of January, 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) :	RHONDA KUKOLY (213), CHRISTINA LEGOUFFE (730), DONNA TIERNEY (569), KRISTEN MURRAY (731), NATALIE MORONEY (610)
Inspection No. / No de l'inspection :	2018_605213_0027
Log No. / No de registre :	023429-17, 003011-18, 007154-18, 008211-18, 014088-18, 014805-18, 015245-18, 024613-18, 027597-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 8, 2019
Licensee / Titulaire de permis :	peopleCare Inc. 735 Bridge Street West, WATERLOO, ON, N2V-2H1
LTC Home / Foyer de SLD :	peopleCare Oakcrossing London 1242 Oakcrossing Road, LONDON, ON, N6H-0G2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Brenda Nethercrott

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

Ministère 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

To peopleCare Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Ministère 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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s.19(1) of the LTCHA.

Specifically, the licensee shall ensure the following:
1. All registered staff will receive training related to catheterization, including a refresher on the procedure, indications for catheterization and requirements.
2. All registered staff will receive training related to accountabilities of their role, Registered Nurse (RN) and Registered Practical Nurse (RPN) as per the College of Nurses of Ontario. Training will include when an RPN should contact an RN and when the RN should contact a physician.
3. Review and revise (revise if necessary), the policy related to families (friends, substitute decision makers, etc.) staying with residents. A record will be kept of the review, date, participants, recommendations and dates of changes made.
4. All registered staff will receive training regarding the home's policy related to (friends, substitute decision makers, etc.) staying with residents.
5. Review and revise (revise if necessary), the policy related to bladder scans, including where the scanner is kept and how it is charged, to ensure it is charged and available at all times. A record will be kept of the review, date, participants, recommendations and dates of changes made.
6. All registered staff will receive training related to completing a bladder scan, where it is to be kept and the process to ensure it remains charged at all times and available for use.
7. All registered staff will receive training related to the process for pronouncing death in the home, both expected and unexpected.
8. All of the above training will be incorporated into the new staff orientation for registered staff.
9. A record of training provided is documented and kept to ensure that all required staff received the above training.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

The Ministry of Health and Long-Term Care received a complaint related to the death of a resident and nursing care in the home at the time of the resident's death.

A record review of the health records for a resident, internal investigation records, policies and procedures, employee files, education records and other documentation was completed. Interviews were conducted with three registered nursing staff members who were on shift on the day that the identified resident passed away as well as the resident's family member, the resident's physician, the Assistant Director of Nursing, the Administrator and the Executive Director.

On an identified date, a resident was found to be physically uncomfortable with specific problematic symptoms.

One registered nursing staff member assessed the resident, ruled out some specific problems, but suspected one specific problem. They contacted the charge nurse on their shift and comfort measures were provided, but the nurse was not able to complete the desired diagnostic test as the machine was left unplugged and was not charged.

The registered nursing staff member asked the family if they wanted the resident sent to hospital and the family declined.

The registered nursing staff member reported the resident's symptoms, actions taken and the need for the test to be done, to the oncoming registered nursing staff member.

The resident had advanced care wishes to not be sent to hospital. The family had requested to stay with the resident in their room while the resident was uncomfortable, this request was denied by the home. The family was told they were allowed to stay in a lounge and they left the home.

Four hours later, the next registered nursing staff member found the resident in

acute distress and discomfort, completed the diagnostic test, found it to be problematic, and called the family to ask to send the resident to hospital. The family asked the registered nursing staff member to perform the nursing procedure and to call the physician. The registered nursing staff member told the family they were not comfortable performing the nursing procedure and that they could not call the physician at that time.

The registered nursing staff member was not comfortable completing a nursing procedure that would have likely improved or alleviated the problem and did not contact the charge nurse in the building or the resident's physician for advice or assistance.

The resident further rapidly declined and the registered nursing staff member called the family again who agreed to send the resident to hospital and then called for an ambulance to come.

The resident passed away when being transferred on to the ambulance stretcher.

The charge nurse was called after the ambulance was called and arrived on the unit after the resident had already passed away and the physician was called after the resident had passed away.

Both the registered nursing staff member and the charge nurse felt that the most important action to take was to ask the family and send the resident to hospital, not to call the charge nurse or the doctor for advice, not for the charge nurse to assess the resident, or to perform a nursing procedure that would likely have alleviated the identified problem for the resident.

The resident passed away within hours of a sudden decline as a result of the originally suspected problem, in distress.

The physician thought that the registered nursing staff member had pronounced the resident deceased.

The registered nursing staff member thought that the charge nurse had pronounced the resident deceased.

The charge nurse thought that the physician had pronounced the resident deceased.

The registered nursing staff member and charge nurse felt it was an unexpected death.

The physician felt it was an expected death, but sooner than expected.

There was no documentation of the pronouncement of death.

The physician felt that the nursing procedure that the registered nursing staff member had been uncomfortable performing may have prevented the problem from worsening and prevented death at that time, and that the resident suffered needlessly as a result. The physician also felt that a nurse in long-term care should have been able and willing to perform the nursing procedure and that the resident's family should have been permitted to stay with the resident.

The Administrator said that the registered nursing staff member should have called the charge nurse and the physician when the resident was found to be in distress and the resident should have had the nursing procedure performed that would have likely improved or alleviated the original problem.

The coroner and the Ministry of Health and Long-Term Care were not notified of an unexpected death or neglect of the resident's needs.

The College of Nurses of Ontario was not notified of the situation involving the resident and the registered nursing staff member.

No action was taken by the home related to the diagnostic test machine being unusable and uncharged.

No education was provided to the registered nursing staff member or charge nurse related to the nursing procedure that would have likely improved or alleviated the problem or documentation of pronouncement of death.

The licensee has failed to ensure that a resident was not neglected by the

licensee or staff when the resident's need for assessment and a nursing procedure was not met and the resident passed away in acute discomfort.

The severity of this issue was determined to be a level 4 as it caused serious injury, harm, impairment or death to the resident. The scope of the issue was a level 1 as it related to one resident of the 23 residents reviewed. The home had a level 2 history as they had no related non-compliance with this section of the LTCHA. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 29, 2019

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

Ministère 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

Order # / Ordre no : 002

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 s.131(2) of O. Reg 79/10.

Specifically, the licensee shall ensure the following:
1. Pharmacy, the Medical Director, the Director of Care and the Administrator evaluate the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs, including review and revise (revise if necessary) the policy related to the emergency supply of medication in the home, to ensure that an emergency supply of medications is available to residents at all time to meet resident's needs as specified by the prescriber. A record will be kept of the evaluation, date, participants, recommendations and dates of changes made.
2. Pharmacy and the Director of Care will complete weekly audits of the emergency supply of medications available in the home, to ensure that an emergency supply of medications is available to residents at all time to meet resident's needs as specified by the prescriber and as outlined in the evaluation.
3. All registered staff will receive training related to the pharmacy and home's policy related to the emergency supply of medication in the home as well as the pharmacy and home's policy related to changes in directions to medications.
4. This training will be incorporated into the new staff orientation for registered staff.
5. A record of training provided is documented and kept to ensure that all required staff received the above training.

Grounds / Motifs :

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

A) The Ministry of Health and Long-Term Care received complaint related to medication administration incidents.

The home's internal investigation notes showed that there were three registered nursing staff members that did not administer an identified medication to a resident.

A review of the home's Medication Incidents documentation showed that that on four identified dates, an identified medication that was to be administered was found in the original packaging, and had not been administered and it was unclear if the previous dose was administered instead. Further review of the medication incident showed that the dosage on the packaging used one particular dosing term and the Electronic Administration Record (eMAR) used a different dosing term. It also said that the new dose of medication was unavailable until med delivery in the evening; however, it was charted as administered. Staff were unable to pull from OMNIcell as it did not have the correct dosage available.

A review of the medication administration audit report and physician's orders for a seven day period of time showed that one of the resident's physicians made changes to the order of an identified medication and the other had not approved it and ordered diagnostic testing. It also showed that on the three previous days, the medication had been documented as on hold. There were no orders to put the identified medication on hold. In addition, it showed that two medications were administered at the same time per the administration documentation and not 30 minutes apart as per the physician's orders prescribed.

The Pharmacy Manager told the Inspector that they also did not have an order to place the identified medication on hold. The resident's Power of Attorney (POA) had been contacted for approval of cost for the medication and that they were waiting for the approval of the medication order and the approval was obtained. The Manager said the eMAR orders were completed by the pharmacy. The Pharmacy Manager stated that if they had been the pharmacist on, they would have notified the home that they did not have the medication, would have directed the nurse to use a liquid form and would have completed the conversion for the correct dosage; however, this change was not communicated by the pharmacy and the nursing staff did not receive any direction.

The medication incident details also stated physician was made aware of medication error. No immediate interventions were required and to continue with weekly diagnostic testing.

The day that the medication incident was discovered, a diagnostic alert was received indicating that an identified test level was abnormal. The registered nurse (RN) was notified and the physician called as well. The physician ordered a stat dose of the medication that had not been administered. Pharmacy was called and informed. The resident's POA was notified regarding abnormal diagnostic level and stat medication order.

The Director of Care (DOC) said that they thought the medication incidents occurred only on four days, and was not aware of the medication not given as prescribed for the three previous days. The DOC further stated that they felt staff might have pulled the two medications at the same time however the administration records of the two medications show they were not given as prescribed which was to be 30 minutes apart.

B) Another resident was to receive an identified medication on a specified date and time. A review of the documentation for Medication Incident's showed that this resident did not receive that medication as it was not available in the OMNIcell. The medication incident report shows that the nurse called the pharmacy to advise them the medication was not available and was advised to split a higher dose tablet into two halves. The dose was not provided at all.

The action plan was that pharmacy would make sure adequate medication was stocked properly before weekends and an action plan would be made for home representative to inform pharmacy if more stock was needed for a certain dose. The medication incident further showed that one nurse had also called the pharmacy earlier that day but was unable to reach the pharmacy.

The DOC stated that the pharmacy stocked three times a week, which had been a change, as they used to stock medication five days a week.

The Pharmacy Manager stated that they were a 24 hour pharmacy and they would send medication by a taxi if required to ensure medication was being

administered as prescribed.

One registered nursing staff member said that they often have to dispense medication from the OMNIcell as they did not have the correct dosage available for administration. They also shared that on the day of the interview with the Inspector, they did not have the correct dosage for a resident as prescribed and needed to pull from two different home areas to get the correct dosage of medication that was a routine medication.

The Administrator stated it was the home's expectation that medications were being administered as prescribed and that staff should not be dispensing medication to ensure that residents were receiving the correct dosage of medication.

C) Another resident was to receive an identified medication twice a day. Medication Incident's documentation showed that this resident was not administered this medication for two days.

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

The severity of this issue was determined to be a level 2 as there was minimal harm to the resident and had the potential to negatively affect the resident's ability to achieve their highest functional status. The scope of the issue was a level 2 as it related to three of six residents reviewed. The home had a level 3 history as they had a related non-compliance with this section of the LTCHA that included:
- Voluntary Plan of Correction (VPC) issued March 19, 2018 (2018_674610_0002)

(610)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 29, 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 8th day of January, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RHONDA KUKOLY

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