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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

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
Jan 25, 2019	2018_739694_0022	005819-18, 032989-18, 033102-18	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care Arthur Nursing Home
215 Eliza Street P.O. Box 700 ARTHUR ON N0G 1A0

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

AMANDA COULTER (694)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 20, 21, 28, 2018, January 2 and 3, 2019.

During the course of the inspection, the following Critical Incidents were inspected; Log #005819-18, Log #033102-18, and Log #032989-18 related to medication administration.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

Inspectors also toured the home, observed provision of resident care, medication administration, reviewed resident clinical records, personnel files, reviewed relevant policies and procedures and interviewed residents and staff.

Inspector #743, Kiyomi Kornetsky, also attended this inspection.

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

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **2 VPC(s)**
- **3 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

The home's policy and procedure entitled, "Transcribing Prescriber's Orders to electronic Medication Administration Record/Treatment Administration Record Sheet" (eMAR/TAR), stated that all prescriber's orders were to be transcribed accurately and completely to the MAR or TAR sheet. Medelink, Medical pharmacies Group limited User's manual, "How to enter a physician's order on Point Click Care (PCC)", stated when a new physician's order was received for a resident, the resident's record on PCC must be updated. The policy entitled "The Medication Pass", stated that all medications administered were to be listed on the resident's eMAR. Each resident was to receive the correct medication in the correct prescribed dosage, at the correct time, and by the correct route. Registered staff were directed to chart administration of all, as needed (PRN), medications on the resident's MAR, the resident progress notes, and on an individual PRN administration record as per the home's policy.

A Critical Incident (CI) was submitted to the Director in December 2018, related to a medication incident that occurred.

In an interview with RPN #103 they stated that on a specific date in December 2018, they were approached by resident #001's family member who identified that the resident appeared uncomfortable. RPN #103 called the physician and received a telephone order for medication for resident #001.

RPN #102 stated they were given a piece of paper by RPN #103 with the order for a certain medication which directed them to give a specific dose of the medication every hour as needed. The order was not transcribed to Point Click Care (PCC). RPN #102 administered a dose of medication to resident #001, prior to the order being transcribed on the resident's eMAR. Resident #001 received ten times the prescribed dose of medication.

The licensee failed to ensure that any medication management system plan, policy, protocol, procedure, strategy, or system instituted or otherwise put in place was complied with to provide safe medication management and optimize effective drug therapy outcomes for resident #001. [s. 8. (1) (b)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one Registered Nurse (RN) who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

The home's staffing was reviewed in relation to a CI that was submitted to the Director, regarding a medication incident that occurred in December 2018. It was identified that at the time of the medication incident there was no RN on duty and present in the home.

The home's staffing plan, staffing schedules, registered staff shift replacement information, agency invoice statements and daily roster sheets for a three-month period were reviewed. On a specific number of occasions the home did not have an RN that was an employee of the licensee present in the home during various shifts.

Staff #101 confirmed that attempts were made to have a RN work all shifts and when this was not possible they scheduled a RPN. The staff member said they were aware the home was expected to have a RN on duty and in the home at all times.

The licensee failed to ensure that they had a RN that was an employee of the licensee and a member of the regular nursing staff of the home on duty and present in the home at all times. [s. 8. (3)]

Additional Required Actions:

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

WN #3: 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 CI was submitted to the Director in December 2018, which reported a medication incident.

On a certain date in December 2018, RPN #103 received a telephone order for resident #001 from Physician #110 for medication to be administered every hour as needed. RPN #103 communicated to RPN #102 the order. The medication record for the medication showed that RPN #102 administered a specific dose of medication to resident #001; instead of the prescribed dose.

RPN #103 was preparing to administer another dose of medication to resident #001 and discovered that the dose administered by RPN #102 was ten times the dose prescribed.

The medication incident form submitted to Medical Pharmacies by RPN #103 on a specific date in December 2018, indicated that an incorrect dose of a medication was administered to resident #001. The resident received ten times the dose of medication than had been prescribed.

The licensee failed to ensure resident #001 was administered the correct dose of morphine in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to immediately report improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.

On a certain date in December 2018, a CI was submitted to the Director regarding a medication error which occurred two days prior. Resident #001 was given an incorrect dose of a medication.

DOC #101 said they were informed about a medication error on the date it occurred.

The licensee failed to immediately report the improper or incompetent treatment or care of resident #001 when a medication administration error occurred that resulted in harm or a risk of harm to resident #001. [s. 24. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure they immediately report improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee failed to ensure a written record relating to the evaluation of the home's staffing plan included the names of the persons who participated in the evaluation, a summary of changes made and the date that those changes were implemented.

The licensee's staffing plan evaluation tool, did not include attendees who participated, a summary of changes made to the home's staffing plan or the date any changes were implemented.

During an interview, Administrator #100 acknowledged the home's staffing plan evaluation tool did not include a summary of changes or the dates the changes were implemented.

The home failed to ensure the evaluation of the home's staffing plan included the names of who participated in the evaluation, a summary of the changes made and the date those changes were implemented. [s. 31. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a written record relating to the evaluation of the home's staffing plan includes the names of the persons who participated in the evaluation, a summary of changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A CI reported a medication incident involving resident #001 in which they were given an incorrect dose of a medication.

Review of the clinical record identified that resident #001's condition had deteriorated and there were no pain assessments completed prior to obtaining an order for pain medication. After the initial dose of pain medication was given, progress notes stated that the family expressed concern to nursing staff that the resident was uncomfortable. Pain assessments were not completed prior to obtaining an order for medication, after the pain medication was given, and when the family expressed to nursing staff that the resident continued to appear uncomfortable.

In an interview with RPN #103, they stated they did not complete a pain assessment when notified by family that the pain medication had not been effective.

The licensee failed to ensure resident #001 was assessed using a clinically appropriate assessment instrument when their pain was not relieved by initial interventions. [s. 52. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider or a registered dietitian, met annually to evaluate the effectiveness of the medication management system and recommend changes.

The Medication Management System program evaluation, was reviewed. There was no record that the Medical Director, the pharmacy service provider and a registered dietitian participated in the annual evaluation of the medication management system in the home.

Administrator #100 acknowledged that the required interdisciplinary team members did not participate in the annual meeting to evaluate the effectiveness of the medication management system.

The licensee failed to ensure that the Medical Director, the pharmacy service provider and a registered dietitian met annually to evaluate the effectiveness of the medication management system and recommend changes. [s. 116. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident is reported to the resident's substitute decision-maker (SDM), the Medical Director and that a written record was kept.

On a certain date in December 2018, a CI was submitted to the Director regarding a missing controlled substance. As per the CI report, the SDM and Medical Director were not notified.

On a certain date in December 2018, RPN #107 documented that the resident's controlled substance was missing.

The home's risk management report, the pharmacy incident report and the CIS report were reviewed and there was no documentation that the SDM or the Medical Director were notified. DOC #101 said they were not able to recall whether the SDM was notified of the medication incident.

The licensee failed to notify resident #002's SDM and the Medical Director when the resident's Butran patch was missing on December 17, 2018. [s. 135. (1)]

Issued on this 31st 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) :	AMANDA COULTER (694)
Inspection No. / No de l'inspection :	2018_739694_0022
Log No. / No de registre :	005819-18, 032989-18, 033102-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 25, 2019
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care Arthur Nursing Home 215 Eliza Street, P.O. Box 700, ARTHUR, ON, N0G-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lindsay Ross

To Caressant-Care Nursing and Retirement Homes Limited, 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 :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 8(1).

Specifically, the licensee shall ensure:

1) All registered staff receive education related to the home's medication management policies and procedures, a record is to be kept of the staff that receive education.
2) All registered staff comply with all aspects of the medication management program, which would include the development and implementation of a quality improvement process to ensure registered staff are compliant with processing orders and high alert/ narcotic administration policies and procedures.

Grounds / Motifs :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system was complied with.

The home's policy and procedure entitled, "Transcribing Prescriber's Orders to electronic Medication Administration Record/Treatment Administration Record Sheet" (eMAR/TAR), stated that all prescriber's orders were to be transcribed accurately and completely to the MAR or TAR sheet. Medelink, Medical pharmacies Group limited User's manual, "How to enter a physician's order on Point Click Care (PCC)", stated when a new physician's order was received for a resident, the resident's record on PCC must be updated. The policy entitled "The

Medication Pass", stated that all medications administered were to be listed on the resident's eMAR. Each resident was to receive the correct medication in the correct prescribed dosage, at the correct time, and by the correct route. Registered staff were directed to chart administration of all, as needed (PRN), medications on the resident's MAR, the resident progress notes, and on an individual PRN administration record as per the home's policy.

A Critical Incident (CI) was submitted to the Director in December 2018, related to a medication incident that occurred.

In an interview with RPN #103 they stated that on a specific date in December 2018, they were approached by resident #001's family member who identified that the resident appeared uncomfortable. RPN #103 called the physician and received a telephone order for medication for resident #001.

RPN #102 stated they were given a piece of paper by RPN #103 with the order for a certain medication which directed them to give a specific dose of the medication every hour as needed. The order was not transcribed to Point Click Care (PCC). RPN #102 administered a dose of medication to resident #001, prior to the order being transcribed on the resident's eMAR. Resident #001 received ten times the prescribed dose of medication.

The licensee failed to ensure that any medication management system plan, policy, protocol, procedure, strategy, or system instituted or otherwise put in place was complied with to provide safe medication management and optimize effective drug therapy outcomes for resident #001.

The scope of this non-compliance was level 1, isolated. The severity of this issue was determined to be a level 3 as there was actual harm/risk. The history of non-compliance is 3, one or more related non-compliance in the last 36 months.
(694)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 05, 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

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 :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must be compliant with s. 8(3) of the Long-Term Care Home Act (LTCHA).

Specifically the licensee shall ensure that at least one Registered Nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Grounds / Motifs :

1. The licensee failed to ensure that at least one Registered Nurse (RN) who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

The home's staffing was reviewed in relation to a CI that was submitted to the Director, regarding a medication incident that occurred in December 2018. It was identified that at the time of the medication incident there was no RN on duty and present in the home.

The home's staffing plan, staffing schedules, registered staff shift replacement information, agency invoice statements and daily roster sheets for a three-month period were reviewed. On a specific number of occasions the home did not have an RN that was an employee of the licensee present in the home during various shifts.

Staff #101 confirmed that attempts were made to have a RN work all shifts and when this was not possible they scheduled a RPN. The staff member said they were aware the home was expected to have a RN on duty and in the home at all times.

The licensee failed to ensure that they had a RN that was an employee of the licensee and a member of the regular nursing staff of the home on duty and present in the home at all times.

The scope of the non-compliance was level 3, widespread as all residents were affected. The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm. The history of non-compliance is one or more unrelated non-compliance in the past 36 months. (694)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 19, 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 : 003

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

Specifically, the licensee shall ensure:
1) All registered staff receive education of the policies and procedures related to narcotic administration, as well as high alert medications, and the expectations when obtaining physician orders and administration.
2) Registered staff receive education on the calculation and administration of sub-cutaneous morphine.
3) Registered staff receive education on the independent and/or double-check system.

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 CI was submitted to the Director in December 2018, which reported a medication incident.

On a certain date in December 2018, RPN #103 received a telephone order for resident #001 from Physician #110 for medication to be administered every hour as needed. RPN #103 communicated to RPN #102 the order. The medication record for the medication showed that RPN #102 administered a specific dose of medication to resident #001; instead of the prescribed dose.

RPN #103 was preparing to administer another dose of medication to resident #001 and discovered that the dose administered by RPN #102 was ten times the dose prescribed.

The medication incident form submitted to Medical Pharmacies by RPN #103 on a specific date in December 2018, indicated that an incorrect dose of a medication was administered to resident #001. The resident received ten times the dose of medication than had been prescribed.

The licensee failed to ensure resident #001 was administered the correct dose of morphine in accordance with the directions for use specified by the prescriber.

The scope of this non-compliance was level 1, isolated. The severity of this issue was determined to be a level 3 as there was actual harm/risk. The history of non-compliance is 2, one or more unrelated non-compliance in the last 36 months. (694)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 05, 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 25th day of January, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amanda Coulter

Service Area Office /
Bureau régional de services : Central West Service Area Office