Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 9, 2017	2017_682549_0011	023837-17	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

CARLINGVIEW MANOR
2330 CARLING AVENUE OTTAWA ON K2B 7H1

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

RENA BOWEN (549)

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): October 24, 25, 26 and November 7, 2017

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), a Registered Dietitian (RD), Food Service Manager, three Clinical Managers (CM), Director of Care, the Assistant Executive Director and the Executive Director.

The inspector reviewed resident health care files, the seventh floor dietary binder, food and fluid intake records, snack intake records, blood sugar records, physician orders and MediSystem Pharmacy policies and procedures titled Nursing Staff Section last reviewed January 17, 2017. The inspector also observed the provision of care provided to residents, staff to resident interactions and several meal services.

The following Inspection Protocols were used during this inspection:
Medication
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

Findings/Faits saillants :

1. The licensee has failed to develop an interdisciplinary medication management system

that provides safe medication management and optimizes effective drug therapy outcomes for residents who have a specific diagnosis including those who are receiving a specific medication and who have specific testings done.

Resident #004 was admitted to the home on a specific date in 2017.

Resident #004 has an order for a specific medication to be administered under specific conditions.

Resident #004's electronic Medication Administration Records (e-MARs) were reviewed by the inspector for a specific period in 2017. There were 11 days in the noted time period where the dosage of the specific medication administered was not documented.

Resident #005 was admitted to the home on a specific date in 2017.

Resident #005 has an order for a specific medication to be administered under specific conditions.

Resident #005's e-MARs were reviewed by the inspector for a specific time period in 2017. There were 20 days in the noted time period where the dosage of the specific medication given was not documented.

During an interview on October 26, 2017 with the Nurse Manager's #103, #105 and #107 it was indicated to the inspector that the expectation when the specific medication is administered to a resident the dosage administered is to be documented in the e-MARs along with the specific test results.

Nurse Manager #103 and #107 indicated that all medications with a varied dose being administered at various times would be expected to have the dosage administered documented.

Nurse Manager #103, #105 and #107 indicated that as part of a resident's care assessment the specific medication dosage administered is required to be documented.

Nurse Manager #103 and #107 indicated during the same interview that if the specific test results are not therapeutic the expectation would be that the registered staff contact the physician before administering the specific medication.

Resident #006 was admitted to the home on a specific date in 2015.

Resident #006 has an order for a specific medication to be administered under specific conditions.

Inspector #549 reviewed the resident's specific test result documentation on the eMars for a specific period in 2017. The resident's specific tests results for specific dates were less than what the Clinical Manager had indicated that the physician should be called for.

The resident's e-Mars also indicated that the resident was administered the specific medication on those identified days.

Inspector #549 reviewed resident #006's progress notes and was unable to locate any documentation indicating that the physician had been notified of the resident's specific tests. The progress notes dated a specific date in 2017 indicate that the resident's specific test was below the therapeutic level. The on call physician was called and ordered resident #006's morning specific medication to be held.

On October 27, 2017, the Assistant Executive Director provided Inspector #549 with a copy of the contracted pharmacy's medication management system titled MediSystem Pharmacy, Nursing Staff Section last reviewed January 17, 2017. The inspector reviewed the document in full. On page 64 of the document there is a procedure titled Medication Administration-a specific medication. This procedure does not include the administration of the specific medication or when the specific test are below the therapeutic level what the registered staff are expected do.

During a telephone interview on October 31, 2017 with RPN #112 it was indicated to Inspector #549 that the dosage she administered was not documented as she thought it was obvious in the physician's order. RPN#112 indicated that she was not aware that the dosage of the specific medication administered was required to be documented.

During a telephone interview with RPN #114 on November 7, 2017 it was indicated to the inspector that she did not know why she did not document the dosage of the specific medication administered.

During an interview on November 6, 2017 with the Executive Director and Assistant Executive Director it was indicated to Inspector #549 that the licensee does not have

written policies or procedures as part of the medication management system specifically for the administration of the specific medication or what is expected of the registered staff when a resident has a specific test result below therapeutic levels.

During an interview with the Executive Director and Assistant Executive Director on November 6, 2017 it was indicated to the inspector that the expectation is that the residents specific test levels and the administration of the specific medication the dosage administered to a resident be documented in the resident's e-MARs. The Executive Director indicated that she did not know why the registered staff are not documenting the dosage of the specific medication administered or calling the physician when a resident's specif test is below a therapeutic level.

The licensee has failed to ensure that there is a developed interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents related to the management of specific diagnosis including the administration of the specific medication or what is expected of the registered staff when a resident specific testing is below a therapeutic level. [s.114. (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 are administered to residents in accordance with the directions for use specified by the prescriber.

Resident #001 was admitted to the home on a specific date in 2017. .

Inspector #549 reviewed resident #001's physician order and electronic Medication Administration Records (e-MARs) for a specific period in 2017.

Resident #001 has a physician's order for a specific medication to be administered under specific conditions.

The resident's e-MARs, progress notes and vital signs portal in Point Click Care (PCC) were reviewed by the Inspector and the Clinical Manager #103 on October 25, 2017.

During a specific period in 2017 there are 18 incidents documented when the resident's specific testing was not therapeutic. No documentation could be located in the e-MARs that the specific medication was administered to resident #001.

During a telephone interview with RPN #112 on October 31, 2017 it was indicated to the inspector that on the specific dates that she did not administer the specific medication to resident #001 she would have taken a second specific test and it would have been therapeutic so the specific medication was not administered to resident #001.

Inspector #549 reviewed the dates that RPN #112 indicated that a second specific test was taken and was unable to find any documentation verifying that a second specific test was taken.

On three specific dates in 2017 the inspector was unable to locate documentation indicating the resident's specific testing was done as ordered. Inspector was unable to verify if resident #001 required the specific medication to be administered on those specific dates.

On a specific date in 2017, the inspector was unable to locate any documented specific test results for a specific time however, the specific medication was documented as being administered.

Resident #004 was admitted to the home on a specific date in 2017.

Inspector reviewed resident #004's e-MARs for the a specific month in 2017. On a specific date during the identified month in 2017 the resident was to receive a specific dosage of the specific medication every morning. The e-MARs indicated that the resident received a different dosage than ordered.

During an interview on November 6, 2017 with RN #101 it was indicated to the inspector that she could not recall the day but thought the entry on that specific date was a documentation error.

Resident #006 was admitted on a specific date in 2015.

The resident has an order for a specific medication to be administered under specific conditions.

Inspector #549 reviewed the resident's e-Mars for a specific month in 2017. The e-Mar indicates that the resident was administered a specific dosage on four separate dates 2017. The inspector reviewed the resident's progress notes for the above noted dates and was unable to locate any documentation indicating why the resident was administered a different dosage than what was ordered.

During a telephone interview on November 7, 2017 with RPN #113 it was indicated to the inspector that she does not remember the specific days that the resident's specific testing was not therapeutic and does not know why she did not administer the specific medication to resident #001.

During an interview with Clinical Manager #103 and #105 on November 6, 2017 it was indicated to the inspector that the expectation is that the specific testing results and the administration of the specific medication and the dosage administered be documented in the resident's e-MARs as soon as the specific medication is administered.

The licensee has failed to ensure that resident #001, #004 and #006's specific medication was administered 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".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 29. Every licensee of a long-term care home shall ensure that when a resident is reassessed and the resident's plan of care is reviewed and revised under subsection 6 (10) of the Act, any consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act, that is relevant, including a regulated document under paragraph 2 of subsection 227 (1) of this Regulation, is reviewed and, if required, revised. O. Reg. 79/10, s. 29.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident is reassessed and the resident's plan of care is reviewed and revised under subsection 6(10) of the Act, consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or "plan of treatment" or a "plan of treatment" under that Act, that is relevant is reviewed and, if required, revised.

Resident #001 is cognitively impaired as indicated in the Minimum Data Set assessment dated a specific date in 2017. The resident's cognitive skills for daily decision-making is moderately impaired- decisions poor; cues or supervision required.

The resident's health care file reviewed by Inspector #549 indicated that care decisions are made by resident #001's Substitute Decision Makers. There are two SDM's listed who can be contacted for care and financial decisions.

At the time of admission on a specific date in 2017 resident #001 was prescribed a specific medication.

Inspector #549 reviewed the resident's physician orders dated a specific date in 2017 which indicated to discontinue the specific medication. The physician's order sheet had a check in the box "Notified POA/Resident with a note stating "message left".

During a telephone interview with SDM #1 on October 24, 2017 it was indicated to Inspector #549 that the home did not notify the SDM that the specific medication was being discontinued. The SDM #1 indicated that he/she would not have agreed with the

medication being discontinued.

During a telephone interview with the SDM #2 on October 26, 2017, it was indicated to Inspector #549 that SDM was not notified that the specific medication was being discontinued. SDM #2 indicated that he/she would not have agreed with the medication being discontinued

Resident #001's progress notes for a specific period in 2017, were reviewed by Inspector #549. Inspector #549 was unable to locate any documentation indicating that either SDM's was notified of the discontinuation of resident #001's specific medication

Both SDMs indicated to the inspector that they became aware that the specific medication was discontinued when the resident was sent to hospital on specific date in 2017.

During an interview with the Assistant Executive Director on October 26, 2017 it was indicated to Inspector #549 that resident #001's SDMs were not notified of the discontinuation of the specific medication.

The licensee failed to receive consent or directive with a "course of treatment" or "plan of treatment" when resident #001's specific medication was discontinued on a specific date in 2017. [s. 29.]

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 that when a resident is reassessed and the resident's plan of care is reviewed and revised under section 6(10) of the Act, any consent or directive with respect to "treatment as defined in the Health Care Consent Act, 1996, including consent or directive with respect to a "course of treatment" or "plan of treatment" under the Act, that is relevant, including a regulated document under paragraph 2 of subsection 227 (1) of this Regulation, is reviewed and , if required , revised, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's response to interventions is documented.

O. Reg. 79/10 s. 68. (2) (d) requires the home to have a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

1. During an interview on October 25, 2017, the Registered Dietitian indicated to Inspector #549 that the home's food and fluid intake monitoring and evaluating system includes daily documentation of food and fluid intake and snack intake for each resident in Point Click Care (PCC). The Registered Dietitian indicated that this information is a resource to be utilized as part of the Nutritional assessment for each resident.

Resident #001 was assessed by the Registered Dietitian as a high nutritional risk on a specific date in 2017 and reassessed on another specific date in 2017 and remained as a high nutritional risk.

The Food Service Manager, the Registered Dietitian and Clinical Manager # 103 indicated to the inspector that it is the responsibility of the Personal Support Worker to complete the Food and Fluid and the Snacks Intake record for their assigned residents. The PSW are to document in the Food and Fluid and Snacks Intake record the amount of food and snack that the resident consumes. The food and snacks intake amounts to be documented for each resident at every meal and snack ranges between 0 to 100%, resident not available, resident refused or not applicable.

During an interview with the Registered Dietitian on October 25, 2017, it was indicated to Inspector #549 that resident #001 is a high nutritional risk. Resident #001 has had a decrease in weight during a specific period in 2017.

Inspector #549 reviewed resident #001's Food Intake record for a specific period in 2017.

On six separate days there was no documentation indicating the resident's food intake for the supper meal, on three separate days there was no documentation indicating the resident's food intake for the breakfast meal and on one day there was no documentation indicating the resident's food intake for the lunch meal.

During a17 days that the resident was in the home there where 10 meals identified were the resident's food intake was not documented.

2. The current written plan of care dated a specific date in 2017 reviewed by the inspector indicates under Nutritional High Risk that resident #001 is to receive a specific snack at (afternoon) PM and a specific snack at (evening) HS snack.

The snack binder was reviewed by the inspector. The snack binder indicates that the resident is to receive a specific snack at the PM and a specific snack at the HS snack.

During an interview with PSW #102 it was indicated to the inspector that the PSWs are responsible for delivering the snack to the residents and documenting in Point Click Care (PCC) the amount that a resident consumes.

Inspector #549 reviewed the Snack Intake records for resident #001 for a specific time period in 2017.

On four separate days during the identified period the inspector was unable to locate documentation indicating that the resident received the required HS snack or refused it. On two separate days during the indicated time period the inspector was unable to locate documentation to indicate that the resident received the PM snack or refused it. On five separate days during the indicated time period the intake records indicates not applicable for the PM snack.

During an interview with the Registered Dietitian on October 25, 2017 it was indicated to the inspector that she does not know why on the five separate days that the Snack Intake

records says "not applicable" as the resident was in the home and a snack would have been sent to the floor for resident #001 as per the plan of care. It was also indicated that if a snack was not sent to the floor the RPN is to request the snack from the kitchen.

During an interview with the Food Service Manager on October 26, 2017, it was indicated that it is the responsibility of the PSWs to ensure resident's receive their snacks and document the amount consumed in PCC.

During an interview with the Assistant Executive Director on October 26, 2017, it was indicated to Inspector #549 that the home's expectation is that each resident's food and snack intake amounts or lack of food and snack intake be documented after each meal in PCC.

The licensee has failed to ensure that resident #001's Food and Snack Intake record was completed after each meal and snack as part of the home's system to monitor and evaluate food intake. [s. 30. (2)]

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 that all resident's food, fluid and snack consumption or lack of consumption is documented in the resident's Food, Fluid and Snack Intake record after each meal and snack, to be implemented voluntarily.

Issued on this 10th day of November, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RENA BOWEN (549)
Inspection No. / No de l'inspection :	2017_682549_0011
Log No. / No de registre :	023837-17
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 9, 2017
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, 000-000
LTC Home / Foyer de SLD :	CARLINGVIEW MANOR 2330 CARLING AVENUE, OTTAWA, ON, K2B-7H1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cathy Drouin

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

Order / Ordre :

The licensee shall:

1. Develop an interdisciplinary medication management system for the management of residents with a specific diagnosis.

2. The interdisciplinary medication management system for the management of the specific diagnosis shall include but not limited to:
a) the assessment and reassessment of residents with the specific diagnosis by a member of the interdisciplinary team.
b) documentation and timely communication of information related to food, fluid and snack intake and specific test results.
c) a process that will give direction to registered nursing staff when specific testing results are low.
d) a process that will give direction to registered nursing staff on documentation requirements for the specific medication administered.
e) best practices in the management of the specific diagnosis.

3. Educate all registered nursing staff in a formal education session and evaluate staff knowledge of the interdisciplinary management system for the management of the specific diagnosis.

4.The licensee must provide enhanced nursing leadership and play an active role in supporting the management team of the home in implementing an interdisciplinary medication management system and staff education related to the medication management system for the management of the specific diagnaosis through the implementation of an evaluation protocol to assess the overall effectiveness of the actions taken in response to this compliance order.

Grounds / Motifs :

1. The licensee has failed to develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents who have a specific diagnosis including those who are receiving a specific medication and who have specific testings done.

Resident #004 was admitted to the home on a specific date in 2017.

Resident #004 has an order for a specific medication to be administered under specific conditions.

Resident #004's electronic Medication Administration Records (e-MARs) were reviewed by the inspector for a specific period in 2017. There were 11 days in the noted time period where the dosage of the specific medication administered was not documented.

Resident #005 was admitted to the home on a specific date in 2017.

Resident #005 has an order for a specific medication to be administered under specific conditions.

Resident #005's e-MARs were reviewed by the inspector for a specific time period in 2017. There were 20 days in the noted time period where the dosage of the specific medication given was not documented.

During an interview on October 26, 2017 with the Nurse Manager's #103, #105 and #107 it was indicated to the inspector that the expectation when the specific medication is administered to a resident the dosage administered is to be documented in the e-MARs along with the specific test results.

Nurse Manager #103 and #107 indicated that all medications with a varied dose being administered at various times would be expected to have the dosage administered documented.

Nurse Manager #103, #105 and #107 indicated that as part of a resident's care assessment the specific medication dosage administered is required to be documented.

Nurse Manager #103 and #107 indicated during the same interview that if the specific test results are not therapeutic the expectation would be that the registered staff contact the physician before administering the specific medication.

Resident #006 was admitted to the home on a specific date in 2015.

Resident #006 has an order for a specific medication to be administered under specific conditions.

Inspector #549 reviewed the resident's specific test result documentation on the

eMars for a specific period in 2017. The resident's specific tests results for specific dates were less than what the Clinical Manager had indicated that the physician should be called for.

The resident's e-Mars also indicated that the resident was administered the specific medication on those identified days.

Inspector #549 reviewed resident #006's progress notes and was unable to locate any documentation indicating that the physician had been notified of the resident's specific tests. The progress notes dated a specific date in 2017 indicate that the resident's specific test was below the therapeutic level. The on call physician was called and ordered resident #006's morning specific medication to be held.

On October 27, 2017, the Assistant Executive Director provided Inspector #549 with a copy of the contracted pharmacy's medication management system titled MediSystem Pharmacy, Nursing Staff Section last reviewed January 17, 2017. The inspector reviewed the document in full. On page 64 of the document there is a procedure titled Medication Administration-a specific medication. This procedure does not include the administration of the specific medication or when the specific test are below the therapeutic level what the registered staff are expected do.

During a telephone interview on October 31, 2017 with RPN #112 it was indicated to Inspector #549 that the dosage she administered was not documented as she thought it was obvious in the physician's order. RPN#112 indicated that she was not aware that the dosage of the specific medication administered was required to be documented.

During a telephone interview with RPN #114 on November 7, 2017 it was indicated to the inspector that she did not know why she did not document the dosage of the specific medication administered.

During an interview on November 6, 2017 with the Executive Director and Assistant Executive Director it was indicated to Inspector #549 that the licensee does not have written policies or procedures as part of the medication management system specifically for the administration of the specific medication or what is expected of the registered staff when a resident has a specific test result below therapeutic levels.

During an interview with the Executive Director and Assistant Executive Director on November 6, 2017 it was indicated to the inspector that the expectation is that the residents specific test levels and the administration of the specific medication the dosage administered to a resident be documented in the resident's e-MARs. The Executive Director indicated that she did not know why the registered staff are not documenting the dosage of the specific medication administered or calling the physician when a resident's specif test is below a therapeutic level.

The licensee has failed to ensure that there is a developed interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents related to the management of specific diagnosis including the administration of the specific medication or what is expected of the registered staff when a resident specific testing is below a therapeutic level. [s.114. (1)]

All though the licensee does not have a non-compliance history for O. Reg. 79/10, 114 (1) a Compliance Order is warranted due to the potential for actual harm of residents and the scope being a pattern (549)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2018

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 shall:

1. Immediately upon being served with this Compliance Order and for 14 consecutive days after that conduct an audit of all electronic medication records (E-Mar) currently in use in all resident home areas for all residents receiving a specific medication to assess the practice of the specific medication administration by the registered nursing staff.

2. Develop an on going eMar audit process that includes a visual verification of all key elements of the specific medication administration process, including but not limited to ensuring that the right resident is receiving the right medications, at the right dose, using the right route at the specified time.

3. Take immediate action when the specific medication administration process does not comply with all applicable professional standards of practice, provincial legislation and pharmacy policies to ensure safe, effective and ethical administration of medications.

4. With the support of the licensee's corporate clinical leadership team educate all registered nursing staff about the specific medication administration process in a formal education session, and evaluate staff knowledge following the session, which should include understanding of the requirement of the administration of the specific medication

Grounds / Motifs :

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

Resident #001 was admitted to the home on a specific date in 2017. .

Inspector #549 reviewed resident #001's physician order and electronic Medication Administration Records (e-MARs) for a specific period in 2017.

Resident #001 has a physician's order for a specific medication to be administered under specific conditions.

The resident's e-MARs, progress notes and vital signs portal in Point Click Care (PCC) were reviewed by the Inspector and the Clinical Manager #103 on October 25, 2017.

During a specific period in 2017 there are 18 incidents documented when the resident's specific testing was not therapeutic. No documentation could be located in the e-MARs that the specific medication was administered to resident #001.

During a telephone interview with RPN #112 on October 31, 2017 it was indicated to the inspector that on the specific dates that she did not administer the specific medication to resident #001 she would have taken a second specific test and it would have been therapeutic so the specific medication was not administered to resident #001.

Inspector #549 reviewed the dates that RPN #112 indicated that a second specific test was taken and was unable to find any documentation verifying that a second specific test was taken.

On three specific dates in 2017 the inspector was unable to locate documentation indicating the resident's specific testing was done as ordered. Inspector was unable to verify if resident #001 required the specific medication to be administered on those specific dates.

On a specific date in 2017, the inspector was unable to locate any documented specific test results for a specific time however, the specific medication was documented as being administered.

Resident #004 was admitted to the home on a specific date in 2017.

Inspector reviewed resident #004's e-MARs for the a specific month in 2017. On a specific date during the identified month in 2017 the resident was to receive a specific dosage of the specific medication every morning. The e-MARs indicated that the resident received a different dosage than ordered.

During an interview on November 6, 2017 with RN #101 it was indicated to the inspector that she could not recall the day but thought the entry on that specific date was a documentation error.

Resident #006 was admitted on a specific date in 2015.

The resident has an order for a specific medication to be administered under specific conditions.

Inspector #549 reviewed the resident's e-Mars for a specific month in 2017. The e-Mar indicates that the resident was administered a specific dosage on four separate dates 2017. The inspector reviewed the resident's progress notes for the above noted dates and was unable to locate any documentation indicating why the resident was administered a different dosage than what was ordered.

During a telephone interview on November 7, 2017 with RPN #113 it was indicated to the inspector that she does not remember the specific days that the resident's specific testing was not therapeutic and does not know why she did not administer the specific medication to resident #001.

During an interview with Clinical Manager #103 and #105 on November 6, 2017 it was indicated to the inspector that the expectation is that the specific testing results and the administration of the specific medication and the dosage administered be documented in the resident's e-MARs as soon as the specific medication is administered.

The licensee has failed to ensure that resident #001, #004 and #006's specific medication was administered in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

A Compliance Order is warranted due to the potential for actual harm of residents. The scope is a pattern. The licensee has a history of non-compliance with O. Reg. 79/10 131(2). Most recently, a Voluntary Plan of Correction was issued September 14, 2017 Inspection #2017_665551_0016, February 7, 2017

Inspection # 2017_617148_0001 and July 28, 2016Insepciton # 2016_200148_0021. (549)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2018

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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 9th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector /
Nom de l'inspecteur : Rena Bowen

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