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
Oct 9, 2018	2018_683126_0018	017922-18, 017923-18	Follow up

Licensee/Titulaire de permis

City of Ottawa
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

Centre d'Accueil Champlain
275 Perrier Street VANIER ON K1L 5C6

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

LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): September 4, 5, 6, 7, 10, 11, 12, 13, 14, 2018

During this inspection the following logs were inspected.
Log #015380-18, Critical Incident (CI) # M511-000024-18 related to Improper/Incompetent treatment
Log #018600-18, CI #M511-000033-18 related to a Medication Adverse Reaction/ Incident.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, the Program Manager for Personal Care (PMPC), the Program Manager Resident Care (PMRC), several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), the Pharmacy Manager, the Pharmacist Consultant, several Personal Support Workers (PSWs) , one family member and several residents.

During the course of the inspection, the inspector reviewed residents' health care records and reviewed relevant policies related to medication adminsitration processes.

The following Inspection Protocols were used during this inspection:
Medication
Minimizing of Restraining
Skin and Wound Care

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 29. (1)	CO #001	2018_548592_0008	126
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #002	2018_548592_0008	126

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. 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.

The home medication management system requires registered nursing staff, the physicians and the pharmacy to do the following:

As per the "Nursing Orientation Document":
• All registered nursing staff shall transcribe new physician order to the Medication Administration Record (MAR)/Treatment Administration Record (TAR)
• Review on a monthly basis the MAR/TAR to match the new MAR with the previous MAR, review the physician prescription in the resident health care record and ensure that the new MAR transcriptions were done correctly and do the necessary correction by either faxing the prescription to the pharmacy or transcribing the physician prescription. Ensure that the Medisystem pen is properly inserted in the pen holder for transmission of the new prescription.
• All registered nursing staff need to ensure that when a medication is discontinued that it is documented in the MAR/TAR, that they apply a green sticker on the discontinued medication, and document.

As per MediSystem Pharmacy Policies and Procedures Manual ON 17-JAN-2017:
"Maintaining the digiMAR/digiTAR Sheets: P21
1. The nurse or facility authorized care provider will be responsible for transcribing all new orders started after the printing of the digiMAR/digiTAR sheets.
2. For a new order, the original Physician's Order Form must be used when orders are being transcribed to the digiMAR/digiTAR sheet.
3. When the resident's medication order is changed (i.e. a dose decrease or increase), this is indicated on the digiMAR/digiTAR sheet by writing "Change of Direction" (COD) or "Discontinued", the date and by crossing it out. The new order should be transcribed into a new space on the digiMAR/digiTAR sheet.
4. If a medication is discontinued, a line should be drawn through the subsequent spaces on the digiMAR/digiTAR sheet and "Discontinued" and the date written above the line. In addition, the box labeled "D/C" must be checked off for reporting purposes.
5. When a medication is ordered for a specific number of days/doses (i.e. antibiotics), this should be noted clearly on the digiMAR/digiTAR sheet with defined start and stop markings.
6. If a correction is needed, place a line through the error and write "Error" or "Mistaken Entry" (M.E.) and initial above the error.

7. For new PRN orders, in addition to transcribing the new order into a new space on the digiMAR/digiTAR sheet, the "PRN" box must also be checked off for reporting purposes. When changing the pastime of a medication, update the time column and check off the 'Time Change' box for reporting purposes.

8. If a medication needs to be reordered, nurses must sign and indicate the current date in one of the four reorder boxes. Once a reorder box is filled in, return the digital Pen to its cradle and all reorder requests will be submitted to the pharmacy.
9. When a resident meets the criteria of Discharged or Deceased an "x" needs to be placed in the top right hand corner of the digiMAR/digiTAR in the appropriate box (DIS = Discharged; DEC = Deceased). This will unlink the resident from the Medication Administration Reminder report. "

"DISCONTINUED MEDICATIONS p.38
Procedure
The staff responsible for transcribing/processing orders will complete the following procedure.
1. Locate the correct the MAR sheet while referring to the appropriate physician order. eMAR Facilities: Discontinue the medication in the Physician Order Entry system.
2. Locate the medication to be discontinued. Put a line through the prescription label and mark it with "Discontinue" and the date.
3. Repack Strip med Home
If the medication appears in the multi-dose strip, circle the medication to be discontinued in red for a 48 hour period and place the balance of the strip into the medication disposal container. A new strip incorporating the change will be sent by pharmacy for the balance of the week, at which time, the remainder of the existing strip can be discarded.
4. Document on the physician order sheet that transcription has been completed as per facility policy.
5. Dock the digital pen if the digital MAR / digital physician order sheet is used
6. Return the faxed Physician's Order Form to the resident's chart. "

"PHYSICIAN'S ORDER REVIEWS / DIGITAL 3 OR 6 MONTH REVIEWS p.52
Policy
Each resident's medication orders must be reviewed every three months for licensed Long Term Care facilities, every 6 months in retirement homes (as per ORCA standards), and as agreed upon with other facilities.
Procedure
1. The pharmacy will provide a Physician's Order Review Form/Digital 3 or 6 Month

Review with the current medication orders for each resident prior to the scheduled review date. It is the home's responsibility to ensure all required, scheduled reviews are received at the appropriate time.
2. At least one nurse will compare the newly printed Physician's Order Review/Digital 3 or 6 Month Review against the resident's current digiMAR/eMAR, recent physician's orders, and last review to check for accuracy, make alterations as necessary, and add new orders that may be missing before the physician reviews it. Some homes may choose to have 2 nursing checks. Refer to facility policy.
3. It is the physician's responsibility to arrange a time to complete the review in a timely fashion once the nurse has completed the first check. Any changes being made by the nurse or the physician on a Digital 3 or 6 Month Review must be made with the digital pen.
4. The completed review must be signed and dated by the physician. All signatures on the Digital 3 or 6 Month Review must be made with the digital pen. Once the pen has been docked all orders will be transmitted to pharmacy.
5. The completed Physician's Order Review/Digital 3 or 6 Month Review can be verified and signed by a second nurse only after all orders have been checked, processed and faxed to the pharmacy. Refer to facility policy.
6. If any changes have been made to the Physician's Order Review (non-digital form), then it must be faxed to pharmacy as soon as possible. When using the Digital Review form, there is no need to fax the pharmacy; all changes will be transmitted via the digital pen.
7. Narcotic medications cannot be authorized using the Digital 3 or 6 Month Review as it does not meet all requirements of a narcotic prescription. As a result, a Narcotic Authorization Request Form will be sent from pharmacy to be signed as authorization for narcotic prescriptions."

Log # 018600-18 related to resident #009:

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

A Critical Incident related to a medication incident/adverse reaction was submitted to the Director on a specific day of July 2018. The day before, resident #009's physician visited the home and in completing the Medication Review, noted that a specific medication was still on the July Medication Administration Record (MAR) when it was discontinued

on a specific day of June 2018 .

Resident #009 was admitted to the home in 2014 with several diagnoses which include dementia.

Resident #009's health care record was reviewed. It was noted that in the Physician Order Sheet dated June 2018, resident's medication was discontinued. On the MAR, it was documented that this medication was discontinued on a specific date of June 2018 as per the physician order and for a period of 15 days this medication was not signed for in the MAR. The July 2018's MAR, this medication was still appearing on the MAR and was signed for as being administered for nineteen days in July. This medication was discontinued a a specific day in July 2018.

In reviewing the Pharmacy Shipping Report (PSR) it was noted that resident #009's medication was delivered to resident #009's unit on a three specific days in June and twice in July 2018.

It was observed that the discontinuance of this medication was not captured during the monthly review of the June to July MARs reconciliation completed by Registered Nurse (RN) #125.

Discussion held with RN #112, indicated that on a specific day of July 2018, the physician noted that the medication was discontinued on a specific date of June 2018 and that resident #009 was still being administered this medication in July 2018.

Discussion held with RN #116, indicated that during the physician round on a specific day of June 2018, resident #009's medication was discontinued on that day. RN #116 indicated that this medication was discontinued on the MAR and a copy of the physician order was faxed to the pharmacy.

Several registered nursing staff have been working during a specific period in June 2018. 2018. RN #112, #114 and #116 were interviewed and indicated that before administering a medication, they need to review the medication order in the MAR to ensure the medications strip match with the MAR. They indicated that if the medications strip does not match the MAR, they have to discard the medication and notify the pharmacy. In this incident, the medication in the medication strip did not match the MAR as it was discontinued on a specific day of June 2018. None of them could recall having discarded this medication or notifying the pharmacy.

There was also discussion regarding the process related to identifying the medication prescribed by the physician as a "priority" or as a "non-priority". RN #116 indicated for the order related to the medication, that this prescription was not identified as a "priority". RN #116 also indicated there could have been some confusion because some staff could have interpreted that the discontinuance of the medication could have started with the next delivery of the medications strip or the following week.

Registered Practical Nurse (RPN) #115 indicated that during that specific period of June 2018, they worked on resident #009's unit on a few occasions. RPN #115 indicated that they noticed that the medication was discontinued in the June's MAR and that the pill was still available in the medication strip that was delivered by the pharmacy. RPN #115 indicated that they discarded this medication but did not notify the RN or call the pharmacy. RPN #113 worked on that unit once during that period and could not recall if this medication was discarded or if the pharmacy was contacted. Furthermore, RPN # 113 indicated that if the medication was not ordered as a priority, then the change in the medication order could occur the following week with the next medications strip delivery.

All these registered nursing staff were aware of the requirement for the utilisation of the Digipen and to put it in the penholder regularly to ensure that it was charged and the "green light" was on.

Discussion held with Program Manager of Resident Care (PMRC) #101 indicated that the pharmacy reported not having received the order of June 2018 and that it was probably related to the utilisation of the Digipen.

Discussion held with Pharmacy Manager #118 indicated that the "priority" and "non-priority" process was developed to facilitate the nurses practices and to minimize the handling of new physician orders. PM #118 indicated that the medication was discontinued and did not require to be identified as a "priority" or as a "non- priority".

Discussion held with Pharmacist Consultant #117 who indicated that the Pharmacy did not received the prescription to discontinue the medication of June 2018. PC #117 indicated that there was a possibility that the Digipen was not used properly, that the nurses did not identify that this medication was still in the medications strip of June, that the pharmacy was never notified and finally during the monthly revision of the June and July's MAR the discontinuance of this medication on that specific day of June 2018 was missed. PC #117 indicated that all of these factors contributed to this medication

incident.

As such, resident #009 continued to be administered the medication up until that specific day of July 2018 when the physician discontinued the medication on a specific day of June 2018.

Log # 015380-18 related to resident #006:

Resident #006 was admitted to the Home in 2017 with several diagnoses. Resident #006 was referred to the Specialized Skin Care Nurse (SSCN) in April 2018.

Resident #006 health care record was reviewed and it was noted that on the Initial Assessment Form (IAF) dated a specific day of April 2018 SSCN recommended a specific treatment. On the IAF, beside the written recommendation, it was noted that someone documented that the physician agreed with the recommended treatment and no date or signature were documented at that time beside that comment. It was also noted that the recommendation was not transcribed in the April and May's Medication Administration Record (MARs). In the April and May's MARs another type of skin treatment/nursing intervention was documented.

On a specific day of May and June 2018, resident #006 was assessed by the SSCN who recommended to continue with the initial April's recommendation. On a specific day of June 2018, the SSCN's treatment was transcribed on the June's MAR.

Discussion held with Registered Nurse (RN) #109 indicated that usually when the SSCN writes a recommendation it is documented on the "Skin and Wound" Monitoring Form (355.29B). Inspector #126 and RN #109 reviewed the May, June and July's MARs and RN# 109 could not provide any reason why the SSCN's treatment was not written on the MARs until a specific day of June 2018.

As such, resident #006 skin treatment recommendations was not transcribed to the MARS until a specific day of June 2018.

During the course of this inspection, it was noted that there was some discrepancies with the medication management system from the physician prescribing an order for medication/ treatment to the administration of the medication/treatment for resident #006 and #009.

The licensee failed to develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. [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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

Log # 018600-18 related to resident #009:

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

A Critical Incident related to a medication incident/adverse reaction was submitted to the Director on a specific day of July 2018. The day before, resident #009's physician visited the home and in completing the Medication Review, noted that a specific medication was still on the July Medication Administration Record (MAR) when it was discontinued on a specific day of June 2018 .

Resident #009 was admitted to the home in 2014 with several diagnoses which include dementia.

Resident #009's health care record was reviewed. It was noted that in the Physician Order Sheet dated June 2018, resident's medication was discontinued. On the MAR, it was documented that this medication was discontinued on a specific date of June 2018 as per the physician order and for a period of 15 days this medication was not signed for

in the MAR. The July 2018's MAR, this medication was still appearing on the MAR and was signed for as being administered for nineteen days in July. This medication was discontinued a a specific day in July 2018.

In reviewing the Pharmacy Shipping Report (PSR) it was noted that resident #009's medication was delivered to resident #009's unit on a three specific days in June and twice in July 2018.

It was observed that the discontinuance of this medication was not captured during the monthly review of the June to July MARs reconciliation completed by Registered Nurse (RN) #125.

Discussion held with RN #112, indicated that on a specific day of July 2018, the physician noted that the medication was discontinued on a specific date of June 2018 and that resident #009 was still being administered this medication in July 2018.

Discussion held with RN #116, indicated that during the physician round on a specific day of June 2018, resident #009's medication was discontinued on that day. RN #116 indicated that this medication was discontinued on the MAR and a copy of the physician order was faxed to the pharmacy.

Several registered nursing staff have been working during a specific period in June 2018. 2018. RN #112, #114 and #116 were interviewed and indicated that before administering a medication, they need to review the medication order in the MAR to ensure the medications strip match with the MAR. They indicated that if the medications strip does not match the MAR, they have to discard the medication and notify the pharmacy. In this incident, the medication in the medication strip did not match the MAR as it was discontinued on a specific day of June 2018. None of them could recall having discarded this medication or notifying the pharmacy.

There was also discussion regarding the process related to identifying the medication prescribed by the physician as a "priority" or as a "non-priority". RN #116 indicated for the order related to the medication, that this prescription was not identified as a "priority". RN #116 also indicated there could have been some confusion because some staff could have interpreted that the discontinuance of the medication could have started with the next delivery of the medications strip or the following week.

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2018, they worked on resident #009's unit on a few occasions. RPN #115 indicated that they noticed that the medication was discontinued in the June's MAR and that the pill was still available in the medication strip that was delivered by the pharmacy. RPN #115 indicated that they discarded this medication but did not notify the RN or call the pharmacy. RPN #113 worked on that unit once during that period and could not recall if this medication was discarded or if the pharmacy was contacted. Furthermore, RPN # 113 indicated that if the medication was not ordered as a priority, then the change in the medication order could occur the following week with the next medications strip delivery.

All these registered nursing staff were aware of the requirement for the utilisation of the Digipen and to put it in the penholder regularly to ensure that it was charged and the "green light" was on.

Discussion held with Program Manager of Resident Care (PMRC) #101 indicated that the pharmacy reported not having received the order of June 2018 and that it was probably related to the utilisation of the Digipen.

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As such, resident #009 continued to be administered the medication up until that specific day of July 2018 when the physician discontinued the medication on a specific day of June 2018.

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

Issued on this 12th day of December, 2018

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

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

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) :	LINDA HARKINS (126)
Inspection No. / No de l'inspection :	2018_683126_0018
Log No. / No de registre :	017922-18, 017923-18
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 9, 2018
Licensee / Titulaire de permis :	City of Ottawa Community and Social Services, Long Term Care Branch, 200 Island Lodge Road, OTTAWA, ON, K1N-5M2
LTC Home / Foyer de SLD :	Centre d'Accueil Champlain 275 Perrier Street, VANIER, ON, K1L-5C6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jacqueline Roy

Ontario

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

To City of Ottawa, 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 must be compliant with O. Reg 79/10, s.114 (1).

Specifically, the licensee shall develop an interdisciplinary medication management system that provides safe medication management system and optimizes effective drug therapy outcomes for residents.

In order to ensure compliance with the medication management system, the licensee shall develop and implement monitoring and remedial processes:

A) At a minimum , adherence to the policies and procedures from the time a new prescription is written by the physician, to the transcription on the Medication Administration Record (MAR), to the monthly and quarterly medication reconciliation revision, to the receiving of the medication strips on a weekly basis from pharmacy and to the administration of the medication/treatment to residents, shall be measured on a weekly basis on all units for a period of 4 consecutive weeks.
B) The licensee shall ensure that corrective action is taken if deviations from established policies and procedures
C) A written record must kept of everything required under (a) and (b).

The severity of this issue was determined to be a level 2 as there was potential for harm. The scope was a level 2. The home had a level 4 Compliance history, with on-going non-compliance with VPC and CO.

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.

The home medication management system requires registered nursing staff, the physicians and the pharmacy to do the following:

As per the "Nursing Orientation Document":
• All registered nursing staff shall transcribe new physician order to the Medication Administration Record (MAR)/Treatment Administration Record (TAR)
• Review on a monthly basis the MAR/TAR to match the new MAR with the previous MAR, review the physician prescription in the resident health care record and ensure that the new MAR transcriptions were done correctly and do the necessary correction by either faxing the prescription to the pharmacy or transcribing the physician prescription. Ensure that the Medisystem pen is properly inserted in the pen holder for transmission of the new prescription.
• All registered nursing staff need to ensure that when a medication is discontinued that it is documented in the MAR/TAR, that they apply a green sticker on the discontinued medication, and document.

As per MediSystem Pharmacy Policies and Procedures Manual ON 17-JAN-2017:
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1. The nurse or facility authorized care provider will be responsible for transcribing all new orders started after the printing of the digiMAR/digiTAR sheets.
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3. When the resident's medication order is changed (i.e. a dose decrease or increase), this is indicated on the digiMAR/digiTAR sheet by writing "Change of Direction" (COD) or "Discontinued", the date and by crossing it out. The new order should be transcribed into a new space on the digiMAR/digiTAR sheet.
4. If a medication is discontinued, a line should be drawn through the subsequent spaces on the digiMAR/digiTAR sheet and "Discontinued" and the date written above the line. In addition, the box labeled "D/C" must be checked off for reporting purposes.
5. When a medication is ordered for a specific number of days/doses (i.e.

antibiotics), this should be noted clearly on the digiMAR/digiTAR sheet with defined start and stop markings.
6. If a correction is needed, place a line through the error and write "Error" or "Mistaken Entry" (M.E.) and initial above the error.
7. For new PRN orders, in addition to transcribing the new order into a new space on the digiMAR/digiTAR sheet, the "PRN" box must also be checked off for reporting purposes. When changing the pastime of a medication, update the time column and check off the 'Time Change' box for reporting purposes.

8. If a medication needs to be reordered, nurses must sign and indicate the current date in one of the four reorder boxes. Once a reorder box is filled in, return the digital Pen to its cradle and all reorder requests will be submitted to the pharmacy.
9. When a resident meets the criteria of Discharged or Deceased an "x" needs to be placed in the top right hand corner of the digiMAR/digiTAR in the appropriate box (DIS = Discharged; DEC = Deceased). This will unlink the resident from the Medication Administration Reminder report. "

"DISCONTINUED MEDICATIONS p.38
Procedure
The staff responsible for transcribing/processing orders will complete the following procedure.
1. Locate the correct the MAR sheet while referring to the appropriate physician order.
eMAR Facilities: Discontinue the medication in the Physician Order Entry system.
2. Locate the medication to be discontinued. Put a line through the prescription label and mark it with "Discontinue" and the date.
3. Repack Strip med Home
If the medication appears in the multi-dose strip, circle the medication to be discontinued in red for a 48 hour period and place the balance of the strip into the medication disposal container. A new strip incorporating the change will be sent by pharmacy for the balance of the week, at which time, the remainder of the existing strip can be discarded.
4. Document on the physician order sheet that transcription has been completed as per facility policy.
5. Dock the digital pen if the digital MAR / digital physician order sheet is used

6. Return the faxed Physician's Order Form to the resident's chart. "

"PHYSICIAN'S ORDER REVIEWS / DIGITAL 3 OR 6 MONTH REVIEWS p.52
Policy
Each resident's medication orders must be reviewed every three months for licensed Long Term Care facilities, every 6 months in retirement homes (as per ORCA standards), and as agreed upon with other facilities.
Procedure
1. The pharmacy will provide a Physician's Order Review Form/Digital 3 or 6 Month Review with the current medication orders for each resident prior to the scheduled review date. It is the home's responsibility to ensure all required, scheduled reviews are received at the appropriate time.
2. At least one nurse will compare the newly printed Physician's Order Review/Digital 3 or 6 Month Review against the resident's current digiMAR/eMAR, recent physician's orders, and last review to check for accuracy, make alterations as necessary, and add new orders that may be missing before the physician reviews it. Some homes may choose to have 2 nursing checks. Refer to facility policy.
3. It is the physician's responsibility to arrange a time to complete the review in a timely fashion once the nurse has completed the first check. Any changes being made by the nurse or the physician on a Digital 3 or 6 Month Review must be made with the digital pen.
4. The completed review must be signed and dated by the physician. All signatures on the Digital 3 or 6 Month Review must be made with the digital pen. Once the pen has been docked all orders will be transmitted to pharmacy.
5. The completed Physician's Order Review/Digital 3 or 6 Month Review can be verified and signed by a second nurse only after all orders have been checked, processed and faxed to the pharmacy. Refer to facility policy.
6. If any changes have been made to the Physician's Order Review (non-digital form), then it must be faxed to pharmacy as soon as possible. When using the Digital Review form, there is no need to fax the pharmacy; all changes will be transmitted via the digital pen.
7. Narcotic medications cannot be authorized using the Digital 3 or 6 Month Review as it does not meet all requirements of a narcotic prescription. As a result, a Narcotic Authorization Request Form will be sent from pharmacy to be signed as authorization for narcotic prescriptions."

Log # 018600-18 related to resident #009:

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

A Critical Incident related to a medication incident/adverse reaction was submitted to the Director on a specific day of July 2018. The day before, resident #009's physician visited the home and in completing the Medication Review, noted that a specific medication was still on the July Medication Administration Record (MAR) when it was discontinued on a specific day of June 2018 .

Resident #009 was admitted to the home in 2014 with several diagnoses which include dementia.

Resident #009's health care record was reviewed. It was noted that in the Physician Order Sheet dated June 2018, resident's medication was discontinued. On the MAR, it was documented that this medication was discontinued on a specific date of June 2018 as per the physician order and for a period of 15 days this medication was not signed for in the MAR. The July 2018's MAR, this medication was still appearing on the MAR and was signed for as being administered for nineteen days in July. This medication was discontinued a a specific day in July 2018.

In reviewing the Pharmacy Shipping Report (PSR) it was noted that resident #009's medication was delivered to resident #009's unit on a three specific days in June and twice in July 2018.

It was observed that the discontinuance of this medication was not captured during the monthly review of the June to July MARs reconciliation completed by Registered Nurse (RN) #125.

Discussion held with RN #112, indicated that on a specific day of July 2018, the physician noted that the medication was discontinued on a specific date of June 2018 and that resident #009 was still being administered this medication in July 2018.

Discussion held with RN #116, indicated that during the physician round on a specific day of June 2018, resident #009's medication was discontinued on that day. RN #116 indicated that this medication was discontinued on the MAR and a copy of the physician order was faxed to the pharmacy.

Several registered nursing staff have been working during a specific period in June 2018. 2018. RN #112, #114 and #116 were interviewed and indicated that before administering a medication, they need to review the medication order in the MAR to ensure the medications strip match with the MAR. They indicated that if the medications strip does not match the MAR, they have to discard the medication and notify the pharmacy. In this incident, the medication in the medication strip did not match the MAR as it was discontinued on a specific day of June 2018. None of them could recall having discarded this medication or notifying the pharmacy.

There was also discussion regarding the process related to identifying the medication prescribed by the physician as a "priority" or as a "non-priority". RN #116 indicated for the order related to the medication, that this prescription was not identified as a "priority". RN #116 also indicated there could have been some confusion because some staff could have interpreted that the discontinuance of the medication could have started with the next delivery of the medications strip or the following week.

Registered Practical Nurse (RPN) #115 indicated that during that specific period of June 2018, they worked on resident #009's unit on a few occasions. RPN #115 indicated that they noticed that the medication was discontinued in the June's MAR and that the pill was still available in the medication strip that was delivered by the pharmacy. RPN #115 indicated that they discarded this medication but did not notify the RN or call the pharmacy. RPN #113 worked on that unit once during that period and could not recall if this medication was discarded or if the pharmacy was contacted. Furthermore, RPN # 113 indicated that if the medication was not ordered as a priority, then the change in the medication order could occur the following week with the next medications strip delivery.

All these registered nursing staff were aware of the requirement for the utilisation of the Digipen and to put it in the penholder regularly to ensure that it was

charged and the "green light" was on.

Discussion held with Program Manager of Resident Care (PMRC) #101 indicated that the pharmacy reported not having received the order of June 2018 and that it was probably related to the utilisation of the Digipen.

Discussion held with Pharmacy Manager #118 indicated that the "priority" and "non-priority" process was developed to facilitate the nurses practices and to minimize the handling of new physician orders. PM #118 indicated that the medication was discontinued and did not require to be identified as a "priority" or as a "non- priority".

Discussion held with Pharmacist Consultant #117 who indicated that the Pharmacy did not received the prescription to discontinue the medication of June 2018. PC #117 indicated that there was a possibility that the Digipen was not used properly, that the nurses did not identify that this medication was still in the medications strip of June, that the pharmacy was never notified and finally during the monthly revision of the June and July's MAR the discontinuance of this medication on that specific day of June 2018 was missed. PC #117 indicated that all of these factors contributed to this medication incident.

As such, resident #009 continued to be administered the medication up until that specific day of July 2018 when the physician discontinued the medication on a specific day of June 2018.

Log # 015380-18 related to resident #006:

Resident #006 was admitted to the Home in 2017 with several diagnoses. Resident #006 was referred to the Specialized Skin Care Nurse (SSCN) in April 2018.

Resident #006 health care record was reviewed and it was noted that on the Initial Assessment Form (IAF) dated a specific day of April 2018 SSCN recommended a specific treatment. On the IAF, beside the written recommendation, it was noted that someone documented that the physician agreed with the recommended treatment and no date or signature were

documented at that time beside that comment. It was also noted that the recommendation was not transcribed in the April and May's Medication Administration Record (MARs). In the April and May's MARs another type of skin treatment/nursing intervention was documented.

On a specific day of May and June 2018, resident #006 was assessed by the SSCN who recommended to continue with the initial April's recommendation. On a specific day of June 2018, the SSCN's treatment was transcribed on the June's MAR.

Discussion held with Registered Nurse (RN) #109 indicated that usually when the SSCN writes a recommendation it is documented on the "Skin and Wound" Monitoring Form (355.29B). Inspector #126 and RN #109 reviewed the May, June and July's MARs and RN# 109 could not provide any reason why the SSCN's treatment was not written on the MARs until a specific day of June 2018.

As such, resident #006 skin treatment recommendations was not transcribed to the MARS until a specific day of June 2018.

During the course of this inspection, it was noted that there was some discrepancies with the medication management system from the physician prescribing an order for medication/ treatment to the administration of the medication/treatment for resident #006 and #009.

The licensee failed to develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. [s. 114. (1)]

The severity of this issue was determined to be a level 2 as there was potential for harm. The scope was a level 2. The home had a level 4 Compliance history, with on-going non-compliance with VPC and CO. (126)

Ontario

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 20, 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
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 9th day of October, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LINDA HARKINS

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