Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 11, 2019	2019_722630_0012 (A1)	006873-19, 006874-19, 006875-19, 006876-19, 006877-19	Follow up

Licensee/Titulaire de permis

Copper Terrace Limited
284 Central Avenue LONDON ON N6B 2C8

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

Copper Terrace
91 Tecumseh Road CHATHAM ON N7M 1B3

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

Amended by AMIE GIBBS-WARD (630) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance due dates for CO #002 and CO #004 were changed to August 31, 2019, at the request of the management in the home.

Issued on this 11st day of July, 2019 (A1)

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

Original report signed by the inspector.

Ontario

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

Amended by AMIE GIBBS-WARD (630) - (A1)

Amended 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): May 13, 14, 15, 16, 17, 21, 22, 23, 24, 27, 28, 29 and 30, 2019.

The following Follow-up intakes were completed within this inspection related to Compliance Orders (COs) from Complaint Inspection 2019_508137_0004:

Log #006877-19 for CO #001 related to registered nurse (RN) staffing;

Log #006873-19 for CO #002 related to the written staffing plan for nursing and personal care services;

Log #006874-19 for CO #003 related to bathing care for residents;

Log #006875-19 for CO #004 related to continence care for residents;

Log #006876-19 for CO #005 related to medication administration.

Documentation of non-compliance related to Complaint Inspection #2019_722630_0014 for Log #008162-19, Log #009104-19, Log #009454-19, Log #009066-19, Log #009323-19, Log #009293-19, Log #009483-19, Log #009296-19 and Log #010152-19 have been included within this Follow-up Inspection Report.

Documentation of non-compliance related to Critical Incident Inspection #2019_722630_0013 for Log #007386-19 has been included within this Follow-up Inspection Report.

During the course of the inspection, the inspector(s) spoke with the Interim Executive Director (ED), the APANS ED Special Projects, the APANS Vice President of Best Practice and Innovation, the Director of Clinical Services (DOCS), the Associate DOCS Second Floor, the Associate DOCS Third Floor, the Resident Assessment Instrument (RAI) Coordinator, the Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN), the BSO Personal Support Worker (PSW), Registered Nurses (RNs), RPNs, a RPN student, PSWs, family members and residents.

The inspectors also observed resident rooms and common areas, observed medication storage areas, observed medication administration, observed meal and snack service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed the written staffing plan of the home for RNs, RPNs and PSWs, reviewed various meeting minutes, reviewed written records of program evaluations and also reviewed the APANS Compliance Action Plan.

Inspection Managers (IMs) Neil Kikuta and Kevin Bachert were also on-site during this inspection.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Medication
Personal Support Services
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **5 WN(s)**
- **0 VPC(s)**
- **4 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
O.Reg 79/10 s. 33. (1)	CO #003	2019_508137_0004	689
O.Reg 79/10 s. 51. (2)	CO #004	2019_508137_0004	630

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that at least one registered nurse, who was both an employee of the licensee and a member of the regular nursing staff of the home, was on duty and present in the home at all times.

The licensee has failed to comply with Compliance Order (CO) #001 from Inspection 2019_508137_0004 served on March 11, 2019, with a compliance due date of April 30, 2019.

The licensee was ordered to ensure that they were compliant with s. 8 (3) of the LTCHA.

Specifically the licensee was ordered to ensure the following:
a) Develop, implement and document a process in the home to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.
b) The licensee must complete a comprehensive assessment of registered staffing plans to achieve compliance with LTCHA, 2007, S.O.2007, c.8, s.8 (3). Once the assessment is completed, strategies to hire staff must be pursued to ensure that there is a back-up plan in place for registered nursing staff that addresses situations when staff cannot come to work, strategies are to be documented and maintained in the home.
c) Registered staff are available to administer all medications to all residents in accordance with use specified by the prescriber.

The licensee completed step b).
The licensee failed to complete step a) and c).

Details regarding non-compliance with step c) has been documented within Written Notification (WN) #4 of this report related to O. Reg 79/10 s 131. (2).

A) The Ministry of Health and Long-Term Care (MOHLTC) received multiple complaints in April and May 2019 related to the staffing levels in the home, including the staffing of Registered Nurses (RNs). These complaints included the following:

i) In April 2019, the MOHLTC received complaint log #008162-19 which identified concerns from an anonymous staff member related to the staffing levels in the home for registered nursing staff. The concerns included that there was not a Registered Nurse (RN) present in the home at all times.

During a follow-up interview this anonymous staff member told Inspector #630 that they had ongoing concerns with the staffing levels in the home. They said that they had concerns that there were shifts in May 2019 when there was no RN coverage in the home. This staff member said that there were times when they thought this was negatively impacting on medication administration for the residents.

ii) In May 2019, the MOHLTC received complaint log #009293-19 which identified concerns from another anonymous staff member related to medication administration and the staffing levels in the home for registered nursing staff.

During a follow-up interview this anonymous staff member told Inspector #630 that on a specific date in May 2019, they had concerns that residents living on Two East did not receive their evening medications related to a shortage of registered nursing staff on that shift.

iii) In May 2019, the MOHLTC received complaint log #009296-19 which identified concerns from a family member related to medication administration and the staffing levels in the home for registered nursing staff.

During a follow-up interview this family member told Inspector #630 that they had concerns with the medication administration for an identified resident on a specific date in May 2019, which was related to the availability of registered nursing staff to administer medications on the evening shift. This family member said that they had concerns with the RN staffing levels in the home and that there had been

times when there was no RN in the home. The family member said they had spoken with the Director of Clinical Services (DOCS) about their concerns with medication administration and they were told it was related to staffing levels and the number of registered nursing staff who had called in for their shift.

iv) In May 2019, the MOHLTC received complaint log #009323-19 which identified concerns from another anonymous staff member related to the RN staffing levels in the home in May 2019.

During a follow-up interview this anonymous staff member told Inspector #630 that the RN working in the home was responsible for resident care on a specific floor in the home which included medication administration, treatments, assessments and working with the doctor. The staff member said that on evenings and on weekends when there was no management in the home the RN was the one who the Registered Practical Nurses (RPNs) contacted if they needed guidance. The staff member said there was a limited number of RNs available to work in the home which made it difficult to cover the fulltime staff when they were on vacation or off. They said the home was using RPNs to replace RN shifts. The staff member said there was no RN working in the home on specific dates in May 2019.

v) In May 2019, the MOHLTC received complaint log #009483-19 which identified concerns from another anonymous staff member related to the staffing levels in the home in May 2019 for registered nursing staff.

During a follow-up interview this anonymous staff member told Inspector #630 that there were shifts in May 2019 when the home was working without full registered nursing staff coverage including no RN in the building.

vi) In May 2019, the MOHLTC received complaint log #010152-19 which identified concerns from another anonymous staff member related to the staffing levels in the home in May 2019 for registered nursing staff including RN staffing.

During a follow-up interview this anonymous staff member told Inspector #630 that on a specific date in May 2019, they thought there were only two registered staff for the whole home instead of five and there was no RN in the building for the evening shift.

B) The home's "2019 Guidelines for Registered Staff Days 0600 to 1400" dated

April 2019 stated "the RN is the leader of the nursing team, providing direction and support, while being respectful of the contributions of all team members. RN will be most responsible and manage staff call-ins/replacements."

The home's written staffing plan titled "Copper Terrace Sufficient Staffing Plan Registered Staff Days and Evening" dated April 2019 indicated on days and evenings there was to be one RN on Three East. The plan stated "all staff are to be replaced using the call-in procedures as per collective agreement."

The home's written staffing plan titled "Copper Terrace Sufficient Staffing Plan Registered and Personal Support Workers (PSW) Nights" dated April 2019 indicated on nights there was to be one RN on Two East. The plan stated "all staff are to be replaced using the call-in procedures as per collective agreement."

The Director of Clinical Services (DOCS) provided a document titled "RN Shifts Missing" from May 1 to May 20, 2019, which showed that on 15 out of 20 (75 per cent) calendar days the home did not have a RN in the building for at least five hours of the 24 hour period. This document also showed that the Associate Director of Clinical Services (ADOCS) was the RN in the building on the day shift five out of 20 (25 per cent) calendar days and for part of the evening shift four out of 20 (20 per cent) calendar days.
The DOCS also provided the "Daily Assignment Sheet" which documented the staffing levels in the home from May 21 to 27, 2019. These forms showed the home did not have a RN working as outlined on the "Copper Terrace Sufficient Staffing Plan" on the day shift for two out of seven calendar days (33 per cent) and on the evening shift for five out of seven (71 per cent) calendar days.

C) During an interview a staff member told Inspector #689 that the home was short staffed for that specific evening shift and that there were only three RPNs working in the home for the four home areas. The RPN stated that they were originally scheduled to work on the third floor east home area but was now working both second and third floor east home areas. The RPN stated that there would not be a Registered Nurse (RN) in the building after management left that they knew of. When asked if they were concerned about resident safety, the RPN stated that they did not think it was safe to take care of residents on two home areas. The RPN stated that they would not complete the medications on time and there would be risk to the residents if they could not get to them to assist them. The RPN stated that they were worried about not satisfying the needs of the residents.

During an interview another staff member told Inspector #630 that the home had been very short registered nursing staff, including RN staffing at specific times in May but the staff worked together and worked extra hours to ensure residents received their medications. This staff member there were times in May 2019 when the registered nursing staff levels had a negative impact on medication administration as some residents did not receive their medications on time. This staff member said that it was difficult to provide residents with the care they required when they were working without the full registered nursing staff complement.

D) During an interview the DOCS told Inspectors #630 and #689 that they were familiar with CO #001 from Inspection #2019_508137_0004 and they had been involved with the implementation of the compliance action plan. The DOCS said that their RN staffing plan included one RN designated to Three East on the day and evening shifts and one RN dedicated to the second floor for the night shift. The DOCS said that the job routine for the RN was similar to the RPN with the added responsibility of being the most responsible nurse in the building and the designated charge person when management was not present in the home. The DOCS said that the staff would consult with the RN for critical incidents or environmental concerns, for trouble shooting and they served as an additional resource for concerns in the home. The DOCS said that when a RN was unable to work their scheduled shift the back-up plan was to cover the shift with a different RN and to offer overtime. The DOCS said that if they could not fill the shift with a RN then it would be replaced by an RPN or at times they had used an agency staffing. The DOCS said that one of the Associate Directors of Clinical Services (ADOCS) was a RN and they would utilize them as the RN in the building as the resource piece and as a clinical resource, but the ADOCS was not considered to be covering the RN shift on Three East for days or evenings. The DOCS acknowledged that based on the staff assignment sheets and the "RN Shifts Missing" summary there had been multiple shifts where there was no RN on duty and present in the home in May 2019. When asked about the impact of these vacancies on resident care, the DOCS said that any shortage of registered nursing staff impacted resident care related to delay in delivery of medications and treatments. The DOCS said that it had been a significant challenge to ensure there was RN coverage in building to provide support to the floor and provide that additional resource for the other registered staff in the building. The DOCS said that they were in good shape with recruitment as well as staff returning to work and within a month the RN shifts should be fully covered in the home.

During an interview the APANS Executive Director Special Projects (EDSP) told Inspector #630 that they were familiar with CO #001 from Inspection #2019_508137_0004 and they had been involved with the implementation of the compliance action plan. When asked if, based on their involvement in the home, there had been a RN who was a member of the staff of the home present in the building at all times in May 2019, the EDSP said no. The EDSP said that the big reason was that they did not have adequate RN staff availability. The EDSP said that they were continuing to work on recruiting and orienting new RN staff. The EDSP said it was the expectation in the home that a RN, who was a member of the staff of the home, would be present in the building at all times.

Based on these interviews and record reviews the licensee has failed to ensure that at least one registered nurse, who is both an employee of the licensee and a member of the regular nursing staff of the home, was on duty and present in the home at all times in May 2019, and as a result failed to comply with Compliance Order (CO) #001 from Inspection 2019_508137_0004 which had a compliance due date of April 30, 2019. (630) [s. 8. (3)]

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place a policy, that the policy was complied with.

Ontario Regulation 79/10 s. 114 (2) states "The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home."

Ontario Regulation 79/10 s. 136 (2) states "The drug destruction and disposal policy must also provide for the following: 1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs. 2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs."

A) The home submitted a Critical Incident System (CIS) report to the MOHLTC which was documented as a "Medication incident/adverse drug reaction." The report stated that a staff member was attempting to dispose an auto-shield needle into a sharps disposal container that was attached to the medication cart and was able to pull multiple medication strips from the sharps container. These medication strips included the intact medication, the residents' unique identifiers as well as their respective medication dose and scheduled time of administration clearly outlined on the package. The report stated that it was determined that another staff member had documented the disposed medications as administered

or refused. This reported incident involved medication strips containing medications for nine residents.

During an interview a staff member told Inspector #563 that they had found two strip packs for identified residents. This staff member stated the corners of the strip packs were observed sticking out of the sharps container at the side of the medication cart and pulled them out. The staff member said at that time they then placed the strip pack in the appropriate drug destruction bin in the medication room. They said then on two other dates they noted the sharps container was stiff again and pulled out more medication strip packs for identified residents. This staff member said they reported the incidents to the Director of Clinical Services (DOCS).

The DOCS provided copies of eMAR reports for specific residents to Inspector #563 and stated that they were highlighted in yellow for the dates the strip pack medications were found in the sharps container. The printed highlighted eMARs were reviewed for and showed that strip pack medications had been found for nine residents and included four different dates in March 2019.

For three of the nine residents, a clinical record review was completed related to the strip pack medications. The electronic Medication Administration Record (eMAR) and the "Medication Admin Audit Report" showed a specific staff member had documented at specific dates and times that these medications had either been refused or administered to the residents.

During an interview the DOCS acknowledged to Inspector #563 that one of the identified residents should have been monitored and blood sugars taken when their diabetes related medications had been documented as refused. The Blood Sugar Summary report did not document blood sugar monitoring on this specific date for this resident.

During an interview the DOCS told Inspector #563 that Daniels Health Canada was a full-service provider of medical, sharps and biohazardous waste disposal, who picked up the sharps unit where the medication strips were discovered to complete an audit.

The "Daniels Diversion Report Audit Results" dated April 16, 2019 was completed "to determine if any meds, specifically intact medication pouches located inside the S14 Sharps Container." The audit noted there was medication waste included

intact medication pouches inside the sharps container along with multiple loose medications.

The home's policy titled "Hogan Pharmacy Partners IIAO1 – Medication Administration, General Guidelines" stated, “medications are administered at the time they are prepared” and "the individual who administered the medication dose would record the administration on the resident’s eMAR directly after the medication was given. At the end of each medication pass, the person who administered the medications would review the eMAR to ensure necessary doses were administered and documented. If a dose of regularly scheduled medication was withheld, refused, not available, or given at a time other than the scheduled time; the appropriate code was to be entered on the eMAR along with an explanation note if appropriate.”

The home's policy titled "Hogan Pharmacy Partners IF01A: Controlled Substance Disposal" stated when a dose of a controlled medication was removed from the Automated Dispensing Cabinet but refused and if the dose was still intact and in the original unit dose packaging, the medication was returned to the “External One-way Locked Narcotic Return Bin” and the return was documented in the Automated Dispensing Cabinet computer and witnessed by a second registered staff member or onsite pharmacy representative.

The home's policy titled "Hogan Pharmacy Partners IF01B: Non-Controlled Medication Disposal" stated all resident specific medications where the resident had refused a dose, or the dose was withheld for any other reason, were immediately placed in the Medication Destruction Bin located in the locked medication room.

A message was posted in the electronic documentation system by the DOCS titled, "ATTENTION ALL REGISTERED STAFF". "Discard all medications strips as well as refused or discontinued in the appropriate disposal container which is the white and blue container in each medication room. Only sharps are to be disposed within the yellow sharps units on each med cart. Refer to the Hogan's disposal policy on each unit."

During an interview the DOCS stated they were familiar with this CIS report and explained when a resident refused a medication there were documentation expectations that included documentation on the eMAR and if there was any specific reason, a progress note would be completed. Inspector #563 asked what

the process was for preparing a medication for administration and the DOCS stated the nurse would refer to the eMAR, care plan and physician's order for direction. The DOCS stated the nurse would then prepare the medication for administration and present it to the resident. The DOCS said that for two of the identified residents their medications were found unprepared, still in the strip packs and disposed of in the sharps container. The DOCS stated those medications were documented as refused, but that the medications were not prepared for administration or offered in the prepared form as the medications were found intact in the sharps container. The DOCS also verified that a specific staff member did not comply with the home's policy" IIAO1 – Medication Administration, General Guidelines" related to preparation, administration and documentation as the staff member documented medications as given when they were not. The DOCS acknowledged the staff member did not prepare medication for administration and did not administer that prepared medication to the resident. The DOCS also verified that this staff member did not comply with the home's policy "IF01A: Controlled Substance Disposal" and the home's "F01B: Non-Controlled Medication Disposal" related to non-controlled and controlled medication disposal as they used the sharps container as the disposal receptacle and not the designated containers provided as outlined in the policies.

The licensee failed to ensure that an identified staff member complied with the home's policies " IIAO1 – Medication Administration, General Guidelines", "IF01A: Controlled Substance Disposal" and "IF01B: Non-Controlled Medication Disposal." (563)

B) A clinical record review in PCC was completed by Inspector #563 for an identified resident related to a CIS report that had been submitted to the MOHLTC. The March 2019 eMAR, progress notes and bowel protocol directives for this resident included "Continence - Bowel Protocol Initiated" progress notes which showed the resident had no bowel movements (BMs) for specific time periods.

The March 2019 Medical Directive (MD) for Bowel Protocol (BP) for day two, day three, and day four did not include the documentation for the administration of specific bowel medications.

During an interview the DOCS stated there was no documentation in the eMAR that the bowel protocol medications were administered and verified there should have been documentation in the eMAR to reflect the medications administered to

this resident. The registered staff did not comply with the home's policy titled "Hogan Pharmacy Partners IIAO1 – Medication Administration, General Guidelines" related to documentation. This policy included "the individual who administered the medication dose would record the administration on the resident's eMAR directly after the medication was given." The bowel protocol medications were not documented as part of the Medical Directive (MD) for Bowel Protocol (BP). (563)

C) During a specific time frame during the inspection, Inspector #563 observed the care provided to residents in a specific area of the home. During this time it was observed that the registered nursing staff member was providing care to residents on two different areas of the home, including medication administration.

The "Medication Admin Audit Report" for a specific area and time period was reviewed for three random residents and the report documented the times of the medication administration for these residents. Based on the observations by Inspector #563, this registered nursing staff member was not present providing the medications to the residents at the times when the medication administration was documented as having been completed.

During an interview one of the identified residents told Inspector #563 they had received their medications at a specific time. This resident was able to appropriately answer questions.

During an interview the observed staff member said they thought the expectation related to the documentation of administration times for medications was that they could be an hour before and an hour after the administration time. Inspector #563 repeated, "A medication can be given between one hour before and one hour after the administration time for a medication" and the staff member replied "yes." The staff member also stated that documentation of a medication was to be done right after the administration to the resident. The staff member explained that the computer had a warning prohibiting the signing of medications earlier than the one hour before and they had to sign for medications later.

The licensee failed to ensure that the home's policy titled "Hogan Pharmacy Partners IIAO1 – Medication Administration, General Guidelines" was complied with. An identified staff member did not record the administration on the eMAR directly after the medication was given for multiple residents. The documentation

of administration times was inaccurate and the staff member was not present in the area when the medications were documented in the PCC electronic Medication Administration Record for multiple residents. (563) [s. 8. (1) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

The licensee has failed to ensure the written staffing plan required for the organized program of nursing services, provided for a staffing mix that was consistent with residents' assessed care and safety needs.

The licensee has failed to comply with Compliance Order (CO) #002 from Inspection 2019_508137_0004 served on March 11, 2019, with a compliance due date of April 30, 2019.

The licensee was ordered to ensure that they were compliant with O. Reg. 79/10 s 31(3).

Specifically the licensee was ordered to:
Prepare, submit and implement a plan for achieving compliance with O.Reg.s.31(3)(a) to ensure the staffing plan must provide for a staffing mix that is consistent with residents' assessed care and safety needs, specifically:

a) Complete a comprehensive assessment of staffing plans to achieve compliance with Reg.79/10, s. 31 (3). Once the assessment is done, strategies to

hire staff must be pursued to ensure that there is a back-up plan in place for nursing and personal care staff that safely addresses situations when staff cannot come to work.

b) Develop, implement and document a process in the home to identify the assessed care and safety needs of the residents in each home area.

c) Develop an action plan, including weekly audits and the person(s) responsible for completing the audits, to ensure that all residents receive their assessed care and safety needs including but not limited to receiving baths twice per week by the method of their choice; proper, timely and safe service and assistance for meals; responding in a timely manner to the resident-staff communication and response system; receiving timely toileting/continence care assistance; medications administered for use as per the prescriber.

d) Any concerns or deficiencies identified in the audits shall be monitored, analyzed, and evaluated to improve the quality of care and services provided to the residents of the long-term care home. The audits shall be documented and kept in the home.

e) Ensure that all nursing and personal support staff are educated on the home's documentation policy including documentation in Point of Care (POC) and Point Click Care (PCC), especially as it is related to bathing documentation. Identify who will be responsible for providing the education and when it will be provided. The education records are to be documented and kept in the home.

The licensee completed step b) and d).

The licensee failed to complete all components of step a), c) and e).

Details regarding non-compliance with step c) have also been documented within Written Notification (WN) #4 of this report related to O. Reg 79/10 s 131. (2).

A) The Ministry of Health and Long-Term Care (MOHLTC) received multiple complaints from Copper Terrace staff in April and May 2019 related to the staffing levels in the home. These complaints included the following:

i) In April 2019, the MOHLTC received complaint log #008162-19 which identified concerns from an anonymous staff member related to the staffing levels in the

home for registered nursing staff.

During a follow-up interview this anonymous staff member told Inspector #630 that they had ongoing concerns with the staffing levels in the home. The staff member said that at times due to staffing medications were not given within the one hour time frame.

ii) In May 2019, the MOHLTC received complaint log #009293-19 which identified concerns from another anonymous staff member related to medication administration and the staffing levels in the home for registered nursing staff.

During a follow-up interview this anonymous staff member told Inspector #630 that on a specific date in May 2019, they had concerns that residents living on Two East did not receive their evening medications related to a shortage of registered nursing staff on that shift.

iii) In May 2019, the MOHLTC received complaint log #009454-19 which identified concerns from another anonymous staff member who said they were very concerned with the staffing levels in the home and that residents were not receiving their medications on time. The staff member reported this had occurred on specific dates during the evening shift.

iv) In May 2019, the MOHLTC received complaint log #009483-19 which identified concerns from another anonymous staff member related to the staffing levels in the home in May 2019 for registered nursing staff.

During a follow-up interview this anonymous staff member told Inspector #630 that there were shifts in May 2019 when the home did not have full registered nursing staff coverage for each floor and they were concerned about safety risks and provision of care for the residents.

v) In May 2019, the MOHLTC received complaint log #010152-19 which identified concerns from another anonymous staff member related to the staffing levels in the home in May 2019 for registered nursing staff.

During a follow-up interview this anonymous staff member told Inspector #630 that on a specific date in May 2019, they thought there were only two registered staff for the whole home instead of five for the evening shift. (630)

B) The home's written staffing plan titled "Copper Terrace Sufficient Staffing Plan – Registered Staff Days and Evenings" dated April 2019 included the following:
- "Staffing current complement: Two East 1 RPN; Three East 1 RN; Two North 1 RPN; Three North 1 RPN; Two/Three North 1 RPN; and comments: 1 RN and 4 RPNs total in building."
- "Down one nurse: Two East 1 RPN; Three East 1 RN; Two North 1 RPN; Three North 1 RPN; and comments: Two North and Three North RPNs will cover their entire respective floor."
- "Down two nurses: RN or RPN if RN not available to cover both East floors; Two North 1 RPN; Three North 1 RPN; and comments: Two North and Three North RPNs will cover their entire respective floor."
- "Down three nurses: 1 nurse to cover Second floor and the other to cover Third floor until help arrives. On call Director to be notified for additional support."
- "Considerations: All staff are to be replaced using the call-in procedure as per collective agreement."
- "Considerations: Attempt to balance existing nurses where possible on all floors and pull depending on need."
- This written staffing plan did not include details related to adjustments to job routines when the full complement of registered nursing staff was not available in the home.

The home's "2019 Guidelines for Registered Staff Days 0600 to 1400" and "2019 Guidelines for Registered Staff Evenings 1400 to 2200" dated April 2019 included the following:
-"The RN is the leader of the nursing team, providing direction and support, while being respectful of the contributions of all team members. RN will be most responsible and manage staff call-ins/replacements."
- "Each registered staff will be responsible for the following group of residents: RN Three East 28 residents RN will be most responsible and manage call-ins/replacement; RPN Two East 28 residents; RPN Three North Rooms 301-314 28 residents; RPN Two North Rooms 201-214 28 residents; RPN Three North and Three North Rooms 216 to 225 and 316 to 325 26 residents."
- These written guidelines did not include details related to adjustments to job routines when the full complement of registered nursing staff was not available in the home.

The Director of Clinical Services (DOCS) provided the "Daily Assignment Sheet" which documented the staffing levels in the home May 1 to 27, 2019. These forms showed the following registered nursing staff shortages:

- 21 out of 27 (77.8 per cent) calendar days down one or more registered nursing staff from full complement;
- 19.5 out of 135 (14.4 per cent) registered nursing staff day shifts were vacant (5 shifts per day shift x 27 days = 135 shifts);
- 19 out of 135 (14.1 per cent) registered nursing staff evening shifts were vacant (5 shifts per evening shift x 27 days = 135 shifts);
- May 1, 2019, three out of five registered nursing staff day shifts were vacant;
- May 5 and 6, 2019, one out of five registered nursing staff evening shifts was vacant with an additional one out of five registered nursing staff evening shifts vacant for half the shift;
- May 19, 2019, three out of five registered nursing staff evening shifts were vacant.

The home's "Staffing Plan Review and Evaluation" dated February 13, 2019, stated "the team evaluated the current staffing patterns in the home and made some adjustments. The adjustments were recommended according to current resident population and needs as evident with the CMI [Case Mix Index]. There was movement with current lines as well as additional lines added to meet the needs of the residents these additional hours exceed the current CMI this year." This evaluation documentation included "Assumption: minimum is one registered staff to 32 residents." (630)

C) In May 2019, the MOHLTC received complaint log #009296-19 which identified concerns from the Power of Attorney (POA) for an identified resident related to medication administration and the staffing levels in the home for registered nursing staff.

During a follow-up interview this family member told Inspector #630 that they had general concerns with the registered nursing staff levels in the home and the provision of medications. They said they had a specific concern with the medication administration for this identified resident on a specific date in May 2019, which was related to the availability of registered nursing staff to administer medications on the evening shift. The complainant reported there was no Registered Practical Nurse (RPN) available to administer the resident's medications. They said a staff member was called in and was able to administer the 1700 hours medications, but not until 1900 hours.

The clinical record for this identified resident included documentation which

showed that their medications on this specific date had not been administered at the scheduled time.

During an interview the DOCS provided a copy of the staff schedule for this specific date and shared with Inspector #563 that the evening shift had five registered staff scheduled, but there were two sick calls and one "no show" leaving two nurses left in the building. The DOCS explained that the staff member who worked day shift returned to work at 1800 hours and the staff member who was the "no show" showed up at 1900 hours. Inspector #563 and the DOCS reviewed other residents and medication times for these dates and the DOCS acknowledged there were multiple residents who had their medications administered several hours later than the prescribed time. The DOCS stated the home was already aware of the late administration times on these dates in May because of the short staffing of RPNs. (563)

D) During an interview a staff member told Inspector #689 that the home was short staffed for that evening shift and that there were only three RPNs working in the home for the four home areas. The RPN stated that they were working in two home areas on that shift. The RPN stated that there would not be a Registered Nurse (RN) in the building after management left that they knew of. When asked if they were concerned about resident safety, the RPN stated that they did not think it was safe to take care of residents on two home areas. The RPN stated that they would not complete the medications on time and there would be risk to the residents if they could not get to them to assist them. The RPN stated that they were worried about not satisfying the needs of the residents. (689)

E) During an interview a staff member told Inspector #630 that the home had been very short for registered staff in May 2019. The staff member said that some staff had been working extra shifts or frequently working double shifts but there were still vacant shifts that were not filled. The staff member said that when there was not the full complement of registered staff in the home then the RPN from the one area would be pulled to the other area. The staff member said that during specific weekends in May 2019 the home was very short registered nursing staff and it affected medication administration. The staff member said that when there were residents who experienced a change of condition, an acute health situation or who required end of life care those became the priority for the registered nursing staff time, which made it more difficult to complete all of their other required duties. The staff member said that when a resident did require end of life care it was hard to spend the time with them that they needed. (630)

F) During an interview a staff member told Inspector #563 that an identified resident missed specific medications on a specific date in May 2019. The staff member said this resident had reported pain and that the resident stated feeling the difference when their pain medication was not administered at the time it was scheduled. The staff member stated this was not the first time residents on a unit missed an entire medication pass where the physician provided a blanket order after the incident. The staff member acknowledged that the residents in a specific area of the home were not administered their medications as prescribed at on a specific date.

In response to this interview and reference to this specific resident, progress notes were reviewed by Inspector #563. There was a progress note documented that the physician had ordered "administer 1600 medication at HS, no duplicate medications due to unforeseen circumstances." The progress notes also included "Resident did state that [they] had a noticeable difference with pain since change in pain medication, and that 1600 missed dose of analgesic did cause some minor discomfort." (563)

G) During an interview an identified resident told Inspector #615 that they usually received their medication before meals depending if there was a shortage of staff, if so they would get their medication late. This resident added that in the past an incident happened where they told the nurse that they were not feeling very good and the nurse told them that they had to go give medication on another floor because they were short of staff and were late administrating the medication.

During an interview a staff member stated that there was two PSWs on shift that evening, that they did not have a PSW float to help and the area was short of one registered nursing staff so that nurse was covering two floors that evening.

During an interview another staff member stated that they were short of one registered nursing staff and that they had to cover two floors. This staff member added that they were overwhelmed and felt distracted.

During an interview another staff member stated that registered staff worked short and had to split the registered nursing staff to two floors to administer medication and that they have been very stressed. (615)

H) During an interview the Director of Clinical Services (DOCS) told Inspectors

#630 and #689 that they were familiar with CO #002 from Inspection #2019_508137_0004 related to the home's staffing plan for personal support services and nursing support services. The DOCS said that they were involved in evaluating and revising the home's staffing plan and that the plan identified that each registered nursing staff was responsible for 26 to 28 residents maximum. The DOCS said that they did have a back-up plan to use when staff called in for their shifts and this directed that the registered staff would cover specific floors. The DOCS said that if the home was down one registered nursing staff the Two/Three North split was pulled and there was one registered staff member to cover each floor. The DOCS said if the home was down two staff then the East registered staff was to cover Two and Three East and one registered staff for Two North and another for Three North. The DOCS said that when there was not a full complement of staff the staff were expected to work together as the staff working on the North floors had 40 residents per floor. The DOCS said that there had been times in May when the home was down two or three registered staff on a shift and this tended to happen more on evenings or weekends. The DOCS said the back-up plan was provided to all staff as a resource and reviewed during staff meeting and this was reviewed and revised but was not a new model. When asked if they had identified concerns related to the completion of assessments or treatments at times when there were vacant RPN or RN shifts, the DOCS said that they had identified concerns with delays in staff completing this when the staff failed to follow the back-up plan. The DOCS said that the success of the staffing back-up plan in meeting the care needs of the residents was variable as it depended on who was working. When asked if they had concerns regarding the staffing plan or the staffing levels in the home in May 2019, the DOCS said that they had concerns when they had staff call-ins which resulted in the home not being fully staffed. The DOCS said that when the home had the full complement of staff they had no concerns. The DOCS said that they had been recruiting and hiring new staff and thought the home would be fully staffed and would be consistently back-filling shifts within the month.

During an interview the APANS Executive Director Special Projects (EDSP) told Inspector #630 that they were familiar with CO #002 from Inspection #2019_508137_0004 and they had been involved with the implementation of the compliance action plan. When asked if, based on their involvement in the home, they had identified any concerns with the staffing levels in the home registered nursing staff or the ability of the staff to meet the care or safety needs of the residents in May, the EDSP said there had been ups and downs with the staffing. The EDSP said there had been shifts that they had not been able to cover and the

home was without the full complement of registered nursing staff. The EDSP said that there had been concerns with medications not being administered on time related in part to staffing shortages.

I) During interviews the DOCS said that in response to requirements for CO #002 the staff in the home had been provided with education regarding the home's documentation policy including documentation in Point of Care (POC) and Point Click Care (PCC). The DOCS said that 88.1 per cent of the staff had completed this documentation and acknowledged that this had not met the requirements of the compliance order. The DOCS said they were continuing to work towards ensuring that all staff completed the required education.

Based on observations, interviews and record reviews the licensee has failed to ensure the written staffing plan required for the organized program of nursing services, provided for a staffing mix that was consistent with residents' assessed care and safety needs. Staff and family members identified concerns with the registered staffing levels in the home in May 2019, especially as they related to medication administration and the consistent ability of the staff the meet the care needs of the residents. The licensee failed to comply with all the requirements of CO #002 as the staffing back-up plan did not adequately address situations when staff were could not go to work as there were multiple shifts with RN and RPN staff shortages and at times medications were not administered to residents as per use by the prescriber. The licensee also failed to ensure all nursing and personal support staff were educated on the home's documentation policy. (630) [s. 31. (3)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with 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).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

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

The licensee has failed to comply with Compliance Order (CO) #005 from Inspection 2019_508137_0004 served on March 11, 2019, with a compliance due date of April 30, 2019.

The licensee was ordered to ensure that they were compliant with O. Reg. 79/10 s. 131 (2).

Specifically, the licensee was ordered to:
a) All medications are administered to all residents in accordance for use specified by the prescriber.
b) That a procedure for tracking and monitoring medication administration times is developed and implemented, including who will be responsible.
The licensee failed to complete step a) and b).

A) The Ministry of Health and Long-Term Care (MOHLTC) received complaint log #009296-19 in May 2019, where the Power of Attorney (POA) for an identified resident reported concerns with nursing/personal support services, administration of drugs, and plan of care. The complainant reported there was no Registered Practical Nurse (RPN) available to administer the resident's medications at 1700 hours on a specific date. A staff member was called in and was able to administer the 1700 hours medications, but not until 1900 hours.

The APANS Health Services-Client Service Response Form was completed in the home in response to a complaint reported by this identified resident's POA. The

form documented that medication was not administered on time for a specific date as the medications were two hours late. The recommended immediate action included an order from the Medical Director at 1830 hours to administer 1600 hours medications at bedtime (HS), and no duplicate medications were to be administered.

The "Medication Admin Audit Report Afternoon Shift" for a specific area for a specific date and the electronic Medication Administration Record (eMAR) documented that specific medications had not been administered to this identified as scheduled. The progress notes included documentation on this specific date which stated "administer 1600 medication at HS, no duplicate medications due to unforeseen circumstances."

During an interview a staff member told Inspector #563 that they did recall this incident regarding the medication administration for this resident. This staff member said that on that shift none of the residents in a specific area had their medications administered at supper. The staff member stated this was very concerning because none of the residents had received their insulin. They said they called the physician and received a "blanket order" for all residents for that area to hold their 1600 hour medications to be given at bedtime (HS) and no duplicate medications. The staff member had to review each medication to make sure doubles were not administered, and the physician's order was to also hold a specific type of insulin, therefore peripheral blood glucose (PBG) monitoring was completed to ensure those residents were "okay" since they had their supper meal and not their order for insulin at that time. The staff member stated this was not the first time residents on a unit missed an entire medication pass where the physician provided a blanket order after the incident. The staff member acknowledged that the residents on this specific area were not administered their medications as scheduled on this specific date.

In response to this staff member's interview and reference to another identified resident, the progress notes were reviewed. The progress notes included documentation on this specific date which stated "administer 1600 medication at HS, no duplicate medications due to unforeseen circumstances." The "Medication Admin Audit Report Afternoon" for a specific area for a specific date and the eMAR documented the following medications were not administered to this identified resident as scheduled.

The licensee failed to ensure that medications were administered to these two

residents in accordance with the directions for use specified by the prescriber.

B) The MOHLTC received complaint log #009293-19 in May 2019, where the anonymous complainant reported that on a specific date residents in a specific area did not receive their medications at the scheduled time. The MOHLTC also received complaint log #009454-19 where the anonymous complainant reported short staffing and medication administration concerns.

The "Medication Admin Audit Report Afternoon Shift" for a specific date and the eMAR were reviewed and two residents were selected for inspection. This showed that medications for the two residents were administered over three hours later than they had been scheduled. A specific insulin order for one of the residents was documented as "hold/see nurse notes" and was not administered.

The "Medication Admin Audit Report Afternoon Shift" for another specific date and the eMAR documented the all 0700 hour medications were administered at 0905 hours for an identified resident.

During an interview, the Director of Clinical Services (DOCS) was informed that there were multiple complaints related to the late administration of medications on in May 2019. The DOCS shared that there were two registered staff in the building on evenings to deliver medications and each nurse was covering two units. Inspector #563 asked if the "blanket" physician's order was in response to late administration of medications and the DOCS replied, "Yes". The DOCS and Inspector #563 reviewed the Medication Admin Audit Reports which showed multiple residents were administered medications including insulin and pain medications late and the DOCS acknowledged that the administration times were several hours late at times.

During an interview a staff member stated they worked specific shifts. The staff member said that on one of the shifts the PSWs on a specific area were worried that everyone needed their bedtime medications and paged the RPNs in the building to administer medications. The staff member acknowledged that medications were delivered almost two hours late on a specific date to residents in a specific area.

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

C) Inspector #563 and the DOCS reviewed other residents and medication times for two specific dates and the DOCS acknowledged multiple residents had their medications administered several hours later than the prescribed time. Time sensitive medications, including insulin, analgesics and antiparkinsonian medications were administered significantly late potentially putting the residents at risk. The "Medication Admin Audit Report" showed several medications were administered from one to four hours later than the scheduled administration time on Two East, Three East and Three North.

During an interview a staff member stated when administering medication, nurses would leave the prompt in the eMAR yellow, administer the medication and hit save to turn the medication administration green to indicate it was delivered to the resident and administered. The staff member said all medications were to be signed for at the time of administration.

The home's policy titled "Hogan Pharmacy Partners IIAO1 – Medication Administration, General Guidelines" stated "When medications are administered from a central location, such as the medication room, medications for the immediate administration time may be prepared not more than 60 minutes in advance for all Residents, or per applicable regulation. In no case, shall more than one dose time be prepared in advance." "A schedule of routine dose administration times is established by the home and utilized on the administration records. Medications are administered within [60 minutes] of scheduled time, except Time-Sensitive Medications (e.g. anti-Parkinson's agents, anti-seizure medications, warfarin) which are administered within [30 minutes] and before, with or after meal orders, which area administered [based on mealtimes]. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the home."

The licensee failed to ensure that medications were administered to residents on Two East, Three East and Three North in accordance with the directions for use specified by the prescriber. (563)

D) In May 2019, the MOHLTC received complaint log #010152-19 related to shortage of staff, no RN in the building and the administration of medications to residents.

A review of the home's policy # IIAO1 "Hogan Pharmacy Partners – Medication Administration, General Guidelines: stated in part "medications are administered

as prescribed in accordance with good nursing principles and practices; Medications are administered in accordance with written orders of the prescriber; Medications are administered at the time they are prepared; The individual who administers the medication dose records the administration on the resident's eMAR directly after the medication is given; At the end of each medication pass, the person administering the medications reviews the eMAR to ensure necessary doses were administered and documented; If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time; the appropriate code is entered on the eMAR along with an explanation note if appropriate".

A review of the eMAR for residents on a specific date, showed identified residents did not receive their specific prescribed medications at bedtime medication pass. The eMAR for another identified resident showed they did not receive a specific prescribed medication for a 21 day period. This also showed that another identified resident did not receive a prescribed medication for a specific period of time in May 2019. A review of the progress notes in PCC and clinical records for all the residents who did not receive their medications did not mentioned the reasons for the medication omissions or document follow-up actions.

During interviews, the DOCS acknowledged to Inspector #615 that medications were not administrated as prescribed to these identified residents and said it was the home's expectation that medications should be administrated as prescribed. (615)

E) Part b) of CO #005 from Inspection 2019_508137_0004 ordered the licensee to ensure "that a procedure for tracking and monitoring medication administration times is developed and implemented, including who will be responsible."

During an interview the Director of Clinical Services (DOCS) stated Hogan Pharmacy completed the "Medication Pass Audit" in April 2019 and the audits were due monthly. The DOCS stated this was the procedure for tracking and monitoring medication administration times and provided two Medication Pass Audits completed in April 2019. The DOCS also stated that the home's policy titled "IIIAO1: Monitoring of Medication Administration" described the procedure and who was responsible. At the time of this inspection, there were no Medication Pass Audits completed in May 2019.

The home's policy titled "Hogan Pharmacy Partners IIIAO1: Monitoring of

Medication Administration policy stated, "The onsite pharmacy representative evaluates medication administration to verify that the resident has received medications in accordance with the prescriber's orders and home policy. Procedures, personnel, and techniques are monitored, and intervention is provided when necessary. Medication monitoring includes, but is not limited to, medication pass observation." The onsite pharmacy representative reviews electronic records to determine that medications are administered at the frequency and times indicated in the prescriber orders.

During an interview, Inspector #563 asked the DOCS how the times for administration were monitored and tracked to ensure residents were administered their medications in accordance for use specified by the prescriber. The DOCS then acknowledged that the audit was ineffective. The DOCS verified the audit did not monitor and track the accuracy of administration times and verified that the "Medication Admin Audit Report" generated in PCC was not reviewed to determine accurate administration times. The acknowledged that the Medication Pass Audit did not provide the information required to monitor and track administration times as specifically outlined in CO #005.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. The licensee also failed to ensure that all components of CO #005 was completed as a procedure for tracking and monitoring medication administration times was not fully developed and implemented. (563) [s. 131. (2)]

2. The licensee failed to ensure that no resident administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident.

The MOHLTC received complaint log #009296-19 in May 2019, which identified that the Power of Attorney (POA) for an identified resident reported concerns with nursing/personal support services, administration of drugs and plan of care. The complainant reported there was no Registered Practical Nurse (RPN) available to administer the resident's medications on a specific date.

During the inspection, a staff member was observed doing medication administration in a specific home area. The staff member indicated that the medication administration was later than usual but that they had two home area to complete medication administration with no one to help. The staff member was

observed pouring a strip pack of medications into a medication cup and then handed the medications to an identified resident and the staff member apologized for being late. The resident was observed saying they wanted specific medications first and the staff member picked out the two pills and gave them to the resident. The resident then took the remainder of the medications in the medication cup into the dining room. The RPN did not supervise the administration of the other medications for this resident.

The plan of care for this resident did not include documentation of a physician's approval for them to self-administer a drug. The resident's profile stated "medications administered with meals in dining room" with no other documentation related to self-administration.

During an interview the staff member was asked what this resident's routine was related to the administration and they stated that the resident had a specific way that they liked to take their medications. The staff member verified that the resident did not have the approval of the physician to self administer medications and it was not included in the resident's plan of care.

During an interview the Director of Clinical Services (DOCS) verified that this resident did not have the approval of their physician to administer medications without the supervision of a nurse. The DOCS also stated that this was an unacceptable risk to other residents in the dining room.

The licensee failed to ensure that this identified resident did not administer a drug to themself unless the administration had been approved by the prescriber in consultation with the resident. (563) [s. 131. (5)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 004

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

On May 29, 2019, there was an email correspondence from the APANS Executive Director of Special Projects (EDSP) to the Director of Clinical Services (DOCS) regarding a meeting in April 2018 where it was decided that the home would change to a different pharmacy provider. The email indicated there was a plan to do a formal annual review in November 2019 after one year of services from the new pharmacy.

The "Pharmacy Report for Professional Advisory Committee" for Quarter “Q1” 2019 (January - March) dated May 8, 2019 at 1100 hours, stated the last date of the annual evaluation of Medication Management System was [to be determined] "TBD".

During an interview the DOCS stated the new pharmacy was hired at the end of June 2018 with a plan to transition in the fall of 2018 with full implementation in November 2018. The DOCS verified they have been employed with the home since May 2018 and that an annual evaluation of the medication management system was not done since May 2018. The APANS EDSP also acknowledged that there was no documented evidence that a formal annual review of the medication management system in the home was completed in 2018.

The licensee failed to ensure that an interdisciplinary team met annually in 2018 to evaluate the effectiveness of the medication management system in the home. (563) [s. 116. (1)]

Issued on this 11st day of July, 2019 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by AMIE GIBBS-WARD (630) - (A1)
Inspection No. / No de l'inspection :	2019_722630_0012 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	006873-19, 006874-19, 006875-19, 006876-19, 006877-19 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 11, 2019(A1)
Licensee / Titulaire de permis :	Copper Terrace Limited 284 Central Avenue, LONDON, ON, N6B-2C8
LTC Home / Foyer de SLD :	Copper Terrace 91 Tecumseh Road, CHATHAM, ON, N7M-1B3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Scott Hebert

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

To Copper Terrace Limited, you are hereby required to comply with the following order (s) by the date(s) set out below:

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_508137_0004, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 8 (3) of the LTCHA.

Specifically the licensee must ensure:

a) At least one registered nurse, who is both an employee of the licensee and a member of the regular nursing staff of the home, is on duty and present in the home at all times.

b) Develop, implement and document a process for the leadership team to evaluate, at least weekly, the RN staffing levels in the home. This evaluation must include the identification of the availability of RN staff in the home to cover all required shifts, the effectiveness of the written staffing back-up plan for RNs, and the effectiveness of strategies to hire and train new RN staff. A written record must be kept in the home of everything related to this evaluation.

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse, who was both an employee of the licensee and a member of the regular nursing staff of the home, was on duty and present in the home at all times.

The licensee has failed to comply with Compliance Order (CO) #001 from Inspection 2019_508137_0004 served on March 11, 2019, with a compliance due date of April 30, 2019.

The licensee was ordered to ensure that they were compliant with s. 8 (3) of the LTCHA.

Specifically the licensee was ordered to ensure the following:
a) Develop, implement and document a process in the home to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.
b) The licensee must complete a comprehensive assessment of registered staffing plans to achieve compliance with LTCHA, 2007, S.O.2007, c.8, s.8 (3). Once the assessment is completed, strategies to hire staff must be pursued to ensure that there is a back-up plan in place for registered nursing staff that addresses situations when staff cannot come to work, strategies are to be documented and maintained in the home.
c) Registered staff are available to administer all medications to all residents in accordance with use specified by the prescriber.

The licensee completed step b).
The licensee failed to complete step a) and c).

Details regarding non-compliance with step c) has been documented within Written Notification (WN) #4 of this report related to O. Reg 79/10 s 131. (2).

A) The Ministry of Health and Long-Term Care (MOHLTC) received multiple complaints in April and May 2019 related to the staffing levels in the home, including the staffing of Registered Nurses (RNs). These complaints included the following:

i) In April 2019, the MOHLTC received complaint log #008162-19 which identified concerns from an anonymous staff member related to the staffing levels in the home for registered nursing staff. The concerns included that there was not a Registered Nurse (RN) present in the home at all times.

During a follow-up interview this anonymous staff member told Inspector #630 that they had ongoing concerns with the staffing levels in the home. They said that they

had concerns that there were shifts in May 2019 when there was no RN coverage in the home. This staff member said that there were times when they thought this was negatively impacting on medication administration for the residents.

ii) In May 2019, the MOHLTC received complaint log #009293-19 which identified concerns from another anonymous staff member related to medication administration and the staffing levels in the home for registered nursing staff.

During a follow-up interview this anonymous staff member told Inspector #630 that on a specific date in May 2019, they had concerns that residents living on Two East did not receive their evening medications related to a shortage of registered nursing staff on that shift.

iii) In May 2019, the MOHLTC received complaint log #009296-19 which identified concerns from a family member related to medication administration and the staffing levels in the home for registered nursing staff.

During a follow-up interview this family member told Inspector #630 that they had concerns with the medication administration for an identified resident on a specific date in May 2019, which was related to the availability of registered nursing staff to administer medications on the evening shift. This family member said that they had concerns with the RN staffing levels in the home and that there had been times when there was no RN in the home. The family member said they had spoken with the Director of Clinical Services (DOCS) about their concerns with medication administration and they were told it was related to staffing levels and the number of registered nursing staff who had called in for their shift.

iv) In May 2019, the MOHLTC received complaint log #009323-19 which identified concerns from another anonymous staff member related to the RN staffing levels in the home in May 2019.

During a follow-up interview this anonymous staff member told Inspector #630 that the RN working in the home was responsible for resident care on a specific floor in the home which included medication administration, treatments, assessments and working with the doctor. The staff member said that on evenings and on weekends when there was no management in the home the RN was the one who the Registered Practical Nurses (RPNs) contacted if they needed guidance. The staff

member said there was a limited number of RNs available to work in the home which made it difficult to cover the fulltime staff when they were on vacation or off. They said the home was using RPNs to replace RN shifts. The staff member said there was no RN working in the home on specific dates in May 2019.

v) In May 2019, the MOHLTC received complaint log #009483-19 which identified concerns from another anonymous staff member related to the staffing levels in the home in May 2019 for registered nursing staff.

During a follow-up interview this anonymous staff member told Inspector #630 that there were shifts in May 2019 when the home was working without full registered nursing staff coverage including no RN in the building.

vi) In May 2019, the MOHLTC received complaint log #010152-19 which identified concerns from another anonymous staff member related to the staffing levels in the home in May 2019 for registered nursing staff including RN staffing.

During a follow-up interview this anonymous staff member told Inspector #630 that on a specific date in May 2019, they thought there were only two registered staff for the whole home instead of five and there was no RN in the building for the evening shift.

B) The home's "2019 Guidelines for Registered Staff Days 0600 to 1400" dated April 2019 stated "the RN is the leader of the nursing team, providing direction and support, while being respectful of the contributions of all team members. RN will be most responsible and manage staff call-ins/replacements."

The home's written staffing plan titled "Copper Terrace Sufficient Staffing Plan Registered Staff Days and Evening" dated April 2019 indicated on days and evenings there was to be one RN on Three East. The plan stated "all staff are to be replaced using the call-in procedures as per collective agreement."

The home's written staffing plan titled "Copper Terrace Sufficient Staffing Plan Registered and Personal Support Workers (PSW) Nights" dated April 2019 indicated on nights there was to be one RN on Two East. The plan stated "all staff are to be replaced using the call-in procedures as per collective agreement."

The Director of Clinical Services (DOCS) provided a document titled "RN Shifts Missing" from May 1 to May 20, 2019, which showed that on 15 out of 20 (75 per cent) calendar days the home did not have a RN in the building for at least five hours of the 24 hour period. This document also showed that the Associate Director of Clinical Services (ADOCS) was the RN in the building on the day shift five out of 20 (25 per cent) calendar days and for part of the evening shift four out of 20 (20 per cent) calendar days.
The DOCS also provided the "Daily Assignment Sheet" which documented the staffing levels in the home from May 21 to 27, 2019. These forms showed the home did not have a RN working as outlined on the "Copper Terrace Sufficient Staffing Plan" on the day shift for two out of seven calendar days (33 per cent) and on the evening shift for five out of seven (71 per cent) calendar days.

C) During an interview a staff member told Inspector #689 that the home was short staffed for that specific evening shift and that there were only three RPNs working in the home for the four home areas. The RPN stated that they were originally scheduled to work on the third floor east home area but was now working both second and third floor east home areas. The RPN stated that there would not be a Registered Nurse (RN) in the building after management left that they knew of. When asked if they were concerned about resident safety, the RPN stated that they did not think it was safe to take care of residents on two home areas. The RPN stated that they would not complete the medications on time and there would be risk to the residents if they could not get to them to assist them. The RPN stated that they were worried about not satisfying the needs of the residents.

During an interview another staff member told Inspector #630 that the home had been very short registered nursing staff, including RN staffing at specific times in May but the staff worked together and worked extra hours to ensure residents received their medications. This staff member there were times in May 2019 when the registered nursing staff levels had a negative impact on medication administration as some residents did not receive their medications on time. This staff member said that it was difficult to provide residents with the care they required when they were working without the full registered nursing staff complement.

D) During an interview the DOCS told Inspectors #630 and #689 that they were familiar with CO #001 from Inspection #2019_508137_0004 and they had been involved with the implementation of the compliance action plan. The DOCS said that

their RN staffing plan included one RN designated to Three East on the day and evening shifts and one RN dedicated to the second floor for the night shift. The DOCS said that the job routine for the RN was similar to the RPN with the added responsibility of being the most responsible nurse in the building and the designated charge person when management was not present in the home. The DOCS said that the staff would consult with the RN for critical incidents or environmental concerns, for trouble shooting and they served as an additional resource for concerns in the home. The DOCS said that when a RN was unable to work their scheduled shift the back-up plan was to cover the shift with a different RN and to offer overtime. The DOCS said that if they could not fill the shift with a RN then it would be replaced by an RPN or at times they had used an agency staffing. The DOCS said that one of the Associate Directors of Clinical Services (ADOCS) was a RN and they would utilize them as the RN in the building as the resource piece and as a clinical resource, but the ADOCS was not considered to be covering the RN shift on Three East for days or evenings. The DOCS acknowledged that based on the staff assignment sheets and the "RN Shifts Missing" summary there had been multiple shifts where there was no RN on duty and present in the home in May 2019. When asked about the impact of these vacancies on resident care, the DOCS said that any shortage of registered nursing staff impacted resident care related to delay in delivery of medications and treatments. The DOCS said that it had been a significant challenge to ensure there was RN coverage in building to provide support to the floor and provide that additional resource for the other registered staff in the building. The DOCS said that they were in good shape with recruitment as well as staff returning to work and within a month the RN shifts should be fully covered in the home.

During an interview the APANS Executive Director Special Projects (EDSP) told Inspector #630 that they were familiar with CO #001 from Inspection #2019_508137_0004 and they had been involved with the implementation of the compliance action plan. When asked if, based on their involvement in the home, there had been a RN who was a member of the staff of the home present in the building at all times in May 2019, the EDSP said no. The EDSP said that the big reason was that they did not have adequate RN staff availability. The EDSP said that they were continuing to work on recruiting and orienting new RN staff. The EDSP said it was the expectation in the home that a RN, who was a member of the staff of the home, would be present in the building at all times.

Based on these interviews and record reviews the licensee has failed to ensure that at least one registered nurse, who is both an employee of the licensee and a member of the regular nursing staff of the home, was on duty and present in the home at all times in May 2019, and as a result failed to comply with Compliance Order (CO) #001 from Inspection 2019_508137_0004 which had a compliance due date of April 30, 2019. (630) [s. 8. (3)]

The severity of this issue was determined to be a level two as there was minimal harm. The scope of the issue was a level three as it was widespread and had the potential to affect a large number of the home's residents. The home had a level four history as they had on-going noncompliance with this section of the LTCHA that included:
- Written Notification (WN), Compliance Order (CO) and Director's Referral (DR) issued March 11, 2019 (2019_508137_0004);
- WN, CO and DR issued November 2, 2018 (2018_607523_0026);
- WN and Voluntary Plan of Correction (VPC) issued May 28, 2018 (2018_563670_0005). (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically the licensee shall:

a) Ensure that the IIAO1 – Medication Administration, General Guidelines policy is complied with. Medications are administered at the time they are prepared and the individual who administers the medication dose is to record the administration on the resident's electronic Medication Administration Record (eMAR) directly after the medication is given.

b) Ensure the IF01A: Controlled Substance Disposal policy is complied with. When a dose of a controlled medication is removed from the Automated Dispensing Cabinet but refused and if the dose is still intact and in the original unit dose packaging, the medication is returned to the "External One-way Locked Narcotic Return Bin" and the return is documented in the Automated Dispensing Cabinet computer and witnessed by a second registered staff member or onsite pharmacy representative.

c) Ensure the IF01B: Non-Controlled Medication Disposal policy is complied with. Resident specific medications where the resident has refused a dose, or the dose is withheld for any other reason, are immediately placed in the Medication Destruction Bin located in the locked medication room.

Grounds / Motifs :

1. The licensee has failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place a policy, that the policy was complied with.

Ontario Regulation 79/10 s. 114 (2) states "The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home."

Ontario Regulation 79/10 s. 136 (2) states "The drug destruction and disposal policy must also provide for the following: 1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal

occurs. 2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs."

A) The home submitted a Critical Incident System (CIS) report to the MOHLTC which was documented as a "Medication incident/adverse drug reaction." The report stated that a staff member was attempting to dispose an auto-shield needle into a sharps disposal container that was attached to the medication cart and was able to pull multiple medication strips from the sharps container. These medication strips included the intact medication, the residents' unique identifiers as well as their respective medication dose and scheduled time of administration clearly outlined on the package. The report stated that it was determined that another staff member had documented the disposed medications as administered or refused. This reported incident involved medication strips containing medications for nine residents.

During an interview a staff member told Inspector #563 that they had found two strip packs for identified residents. This staff member stated the corners of the strip packs were observed sticking out of the sharps container at the side of the medication cart and pulled them out. The staff member said at that time they then placed the strip pack in the appropriate drug destruction bin in the medication room. They said then on two other dates they noted the sharps container was stiff again and pulled out more medication strip packs for identified residents. This staff member said they reported the incidents to the Director of Clinical Services (DOCS).

The DOCS provided copies of eMAR reports for specific residents to Inspector #563 and stated that they were highlighted in yellow for the dates the strip pack medications were found in the sharps container. The printed highlighted eMARs were reviewed for and showed that strip pack medications had been found for nine residents and included four different dates in March 2019.

For three of the nine residents, a clinical record review was completed related to the strip pack medications. The electronic Medication Administration Record (eMAR) and the "Medication Admin Audit Report" showed a specific staff member had documented at specific dates and times that these medications had either been refused or administered to the residents.

During an interview the DOCS acknowledged to Inspector #563 that one of the identified residents should have been monitored and blood sugars taken when their diabetes related medications had been documented as refused. The Blood Sugar Summary report did not document blood sugar monitoring on this specific date for this resident.

During an interview the DOCS told Inspector #563 that Daniels Health Canada was a full-service provider of medical, sharps and biohazardous waste disposal, who picked up the sharps unit where the medication strips were discovered to complete an audit.

The "Daniels Diversion Report Audit Results" dated April 16, 2019 was completed "to determine if any meds, specifically intact medication pouches located inside the S14 Sharps Container." The audit noted there was medication waste included intact medication pouches inside the sharps container along with multiple loose medications.

The home's policy titled "Hogan Pharmacy Partners IIAO1 – Medication Administration, General Guidelines" stated, "medications are administered at the time they are prepared" and "the individual who administered the medication dose would record the administration on the resident's eMAR directly after the medication was given. At the end of each medication pass, the person who administered the medications would review the eMAR to ensure necessary doses were administered and documented. If a dose of regularly scheduled medication was withheld, refused, not available, or given at a time other than the scheduled time; the appropriate code was to be entered on the eMAR along with an explanation note if appropriate."

The home's policy titled "Hogan Pharmacy Partners IF01A: Controlled Substance Disposal" stated when a dose of a controlled medication was removed from the Automated Dispensing Cabinet but refused and if the dose was still intact and in the original unit dose packaging, the medication was returned to the "External One-way Locked Narcotic Return Bin" and the return was documented in the Automated Dispensing Cabinet computer and witnessed by a second registered staff member or onsite pharmacy representative.

The home's policy titled "Hogan Pharmacy Partners IF01B: Non-Controlled Medication Disposal" stated all resident specific medications where the resident had

refused a dose, or the dose was withheld for any other reason, were immediately placed in the Medication Destruction Bin located in the locked medication room.

A message was posted in the electronic documentation system by the DOCS titled, "ATTENTION ALL REGISTERED STAFF". "Discard all medications strips as well as refused or discontinued in the appropriate disposal container which is the white and blue container in each medication room. Only sharps are to be disposed within the yellow sharps units on each med cart. Refer to the Hogan's disposal policy on each unit."

During an interview the DOCS stated they were familiar with this CIS report and explained when a resident refused a medication there were documentation expectations that included documentation on the eMAR and if there was any specific reason, a progress note would be completed. Inspector #563 asked what the process was for preparing a medication for administration and the DOCS stated the nurse would refer to the eMAR, care plan and physician's order for direction. The DOCS stated the nurse would then prepare the medication for administration and present it to the resident. The DOCS said that for two of the identified residents their medications were found unprepared, still in the strip packs and disposed of in the sharps container. The DOCS stated those medications were documented as refused, but that the medications were not prepared for administration or offered in the prepared form as the medications were found intact in the sharps container. The DOCS also verified that a specific staff member did not comply with the home's policy" IIAO1 – Medication Administration, General Guidelines" related to preparation, administration and documentation as the staff member documented medications as given when they were not. The DOCS acknowledged the staff member did not prepare medication for administration and did not administer that prepared medication to the resident. The DOCS also verified that this staff member did not comply with the home's policy "IF01A: Controlled Substance Disposal" and the home's "F01B: Non-Controlled Medication Disposal" related to non-controlled and controlled medication disposal as they used the sharps container as the disposal receptacle and not the designated containers provided as outlined in the policies.

The licensee failed to ensure that an identified staff member complied with the home's policies " IIAO1 – Medication Administration, General Guidelines", "IF01A: Controlled Substance Disposal" and "IF01B: Non-Controlled Medication Disposal." (563)

B) A clinical record review in PCC was completed by Inspector #563 for an identified resident related to a CIS report that had been submitted to the MOHLTC. The March 2019 eMAR, progress notes and bowel protocol directives for this resident included "Continence - Bowel Protocol Initiated" progress notes which showed the resident had no bowel movements (BMs) for specific time periods.

The March 2019 Medical Directive (MD) for Bowel Protocol (BP) for day two, day three, and day four did not include the documentation for the administration of specific bowel medications.

During an interview the DOCS stated there was no documentation in the eMAR that the bowel protocol medications were administered and verified there should have been documentation in the eMAR to reflect the medications administered to this resident. The registered staff did not comply with the home's policy titled "Hogan Pharmacy Partners IIAO1 – Medication Administration, General Guidelines" related to documentation. This policy included "the individual who administered the medication dose would record the administration on the resident's eMAR directly after the medication was given." The bowel protocol medications were not documented as part of the Medical Directive (MD) for Bowel Protocol (BP). (563)

C) During a specific time frame during the inspection, Inspector #563 observed the care provided to residents in a specific area of the home. During this time it was observed that the registered nursing staff member was providing care to residents on two different areas of the home, including medication administration.

The "Medication Admin Audit Report" for a specific area and time period was reviewed for three random residents and the report documented the times of the medication administration for these residents. Based on the observations by Inspector #563, this registered nursing staff member was not present providing the medications to the residents at the times when the medication administration was documented as having been completed.

During an interview one of the identified residents told Inspector #563 they had received their medications at a specific time. This resident was able to appropriately answer questions.

During an interview the observed staff member said they thought the expectation related to the documentation of administration times for medications was that they could be an hour before and an hour after the administration time. Inspector #563 repeated, "A medication can be given between one hour before and one hour after the administration time for a medication" and the staff member replied "yes." The staff member also stated that documentation of a medication was to be done right after the administration to the resident. The staff member explained that the computer had a warning prohibiting the signing of medications earlier than the one hour before and they had to sign for medications later.

The licensee failed to ensure that the home's policy titled "Hogan Pharmacy Partners IIAO1 – Medication Administration, General Guidelines" was complied with. An identified staff member did not record the administration on the eMAR directly after the medication was given for multiple residents. The documentation of administration times was inaccurate and the staff member was not present in the area when the medications were documented in the PCC electronic Medication Administration Record for multiple residents. (563) [s. 8. (1) (b)]

The severity of this issue was determined to be a level two as there was minimal harm. The scope of the issue was a level three as it was widespread and had the potential to affect a large number of the home's residents. The home had a level two history as they had no history of non-compliance with this section of O. Reg.79/10. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2019(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2019_508137_0004, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee must be compliant with O. Reg.79/10 s.31(3).

Specifically the licensee must ensure:

a) Ensure the written staffing plan required for the organized program of nursing services and the organized program of personal support services under clause 8 (1)(b) of the Act, provides for a staffing mix that is consistent with residents' assessed care and safety needs.

b) Evaluate and revise the job routines and the written staffing back-up plan to ensure they provide clear direction for registered nursing staff on the staffing procedures in place to ensure all residents' care and safety needs are consistently met, including situations when there is not a full complement of registered nursing staff available to work in the home. This must include an evaluation of the job routines and the written staffing back-up plan as they relate to medication administration. A written record must be kept in the home of everything related to this evaluation.

c) Develop, implement and document a process for the leadership team to evaluate, at least weekly, the registered nursing staff levels in the home. This evaluation must include the identification of the availability of registered nursing staff in the home to cover all required shifts, the effectiveness of the written staffing back-up plan as well as the effectiveness of strategies to hire and train new registered nursing staff. A written record must be kept in the home of everything related to this evaluation.

Grounds / Motifs :

1. The licensee has failed to ensure the written staffing plan required for the organized program of nursing services, provided for a staffing mix that was consistent with residents' assessed care and safety needs.

The licensee has failed to comply with Compliance Order (CO) #002 from Inspection 2019_508137_0004 served on March 11, 2019, with a compliance due date of April 30, 2019.

The licensee was ordered to ensure that they were compliant with O. Reg. 79/10 s 31(3).

Specifically the licensee was ordered to:
Prepare, submit and implement a plan for achieving compliance with O.Reg.s.31(3)(a) to ensure the staffing plan must provide for a staffing mix that is consistent with residents' assessed care and safety needs, specifically:

a) Complete a comprehensive assessment of staffing plans to achieve compliance with Reg.79/10, s. 31 (3). Once the assessment is done, strategies to hire staff must be pursued to ensure that there is a back-up plan in place for nursing and personal care staff that safely addresses situations when staff cannot come to work.

b) Develop, implement and document a process in the home to identify the assessed care and safety needs of the residents in each home area.

c) Develop an action plan, including weekly audits and the person(s) responsible for completing the audits, to ensure that all residents receive their assessed care and safety needs including but not limited to receiving baths twice per week by the method of their choice; proper, timely and safe service and assistance for meals; responding in a timely manner to the resident-staff communication and response system; receiving timely toileting/continence care assistance; medications administered for use as per the prescriber.

d) Any concerns or deficiencies identified in the audits shall be monitored, analyzed, and evaluated to improve the quality of care and services provided to the residents of the long-term care home. The audits shall be documented and kept in the home.

e) Ensure that all nursing and personal support staff are educated on the home's documentation policy including documentation in Point of Care (POC) and Point Click Care (PCC), especially as it is related to bathing documentation. Identify who will be responsible for providing the education and when it will be provided. The education records are to be documented and kept in the home.

The licensee completed step b) and d).

The licensee failed to complete all components of step a), c) and e).

Details regarding non-compliance with step c) have also been documented within

Written Notification (WN) #4 of this report related to O. Reg 79/10 s 131. (2).

A) The Ministry of Health and Long-Term Care (MOHLTC) received multiple complaints from Copper Terrace staff in April and May 2019 related to the staffing levels in the home. These complaints included the following:

i) In April 2019, the MOHLTC received complaint log #008162-19 which identified concerns from an anonymous staff member related to the staffing levels in the home for registered nursing staff.

During a follow-up interview this anonymous staff member told Inspector #630 that they had ongoing concerns with the staffing levels in the home. The staff member said that at times due to staffing medications were not given within the one hour time frame.

ii) In May 2019, the MOHLTC received complaint log #009293-19 which identified concerns from another anonymous staff member related to medication administration and the staffing levels in the home for registered nursing staff.

During a follow-up interview this anonymous staff member told Inspector #630 that on a specific date in May 2019, they had concerns that residents living on Two East did not receive their evening medications related to a shortage of registered nursing staff on that shift.

iii) In May 2019, the MOHLTC received complaint log #009454-19 which identified concerns from another anonymous staff member who said they were very concerned with the staffing levels in the home and that residents were not receiving their medications on time. The staff member reported this had occurred on specific dates during the evening shift.

iv) In May 2019, the MOHLTC received complaint log #009483-19 which identified concerns from another anonymous staff member related to the staffing levels in the home in May 2019 for registered nursing staff.

During a follow-up interview this anonymous staff member told Inspector #630 that there were shifts in May 2019 when the home did not have full registered nursing staff coverage for each floor and they were concerned about safety risks and

provision of care for the residents.

v) In May 2019, the MOHLTC received complaint log #010152-19 which identified concerns from another anonymous staff member related to the staffing levels in the home in May 2019 for registered nursing staff.

During a follow-up interview this anonymous staff member told Inspector #630 that on a specific date in May 2019, they thought there were only two registered staff for the whole home instead of five for the evening shift. (630)

B) The home's written staffing plan titled "Copper Terrace Sufficient Staffing Plan – Registered Staff Days and Evenings" dated April 2019 included the following:
- "Staffing current complement: Two East 1 RPN; Three East 1 RN; Two North 1 RPN; Three North 1 RPN; Two/Three North 1 RPN; and comments: 1 RN and 4 RPNs total in building."
- "Down one nurse: Two East 1 RPN; Three East 1 RN; Two North 1 RPN; Three North 1 RPN; and comments: Two North and Three North RPNs will cover their entire respective floor."
- "Down two nurses: RN or RPN if RN not available to cover both East floors; Two North 1 RPN; Three North 1 RPN; and comments: Two North and Three North RPNs will cover their entire respective floor."
- "Down three nurses: 1 nurse to cover Second floor and the other to cover Third floor until help arrives. On call Director to be notified for additional support."
- "Considerations: All staff are to be replaced using the call-in procedure as per collective agreement."
- "Considerations: Attempt to balance existing nurses where possible on all floors and pull depending on need."
- This written staffing plan did not include details related to adjustments to job routines when the full complement of registered nursing staff was not available in the home.

The home's "2019 Guidelines for Registered Staff Days 0600 to 1400" and "2019 Guidelines for Registered Staff Evenings 1400 to 2200" dated April 2019 included the following:
-"The RN is the leader of the nursing team, providing direction and support, while being respectful of the contributions of all team members. RN will be most responsible and manage staff call-ins/replacements."

- "Each registered staff will be responsible for the following group of residents: RN Three East 28 residents RN will be most responsible and manage call-ins/replacement; RPN Two East 28 residents; RPN Three North Rooms 301-314 28 residents; RPN Two North Rooms 201-214 28 residents; RPN Three North and Three North Rooms 216 to 225 and 316 to 325 26 residents."
- These written guidelines did not include details related to adjustments to job routines when the full complement of registered nursing staff was not available in the home.

The Director of Clinical Services (DOCS) provided the "Daily Assignment Sheet" which documented the staffing levels in the home May 1 to 27, 2019. These forms showed the following registered nursing staff shortages:

- 21 out of 27 (77.8 per cent) calendar days down one or more registered nursing staff from full complement;
- 19.5 out of 135 (14.4 per cent) registered nursing staff day shifts were vacant (5 shifts per day shift x 27 days = 135 shifts);
- 19 out of 135 (14.1 per cent) registered nursing staff evening shifts were vacant (5 shifts per evening shift x 27 days = 135 shifts);
- May 1, 2019, three out of five registered nursing staff day shifts were vacant;
- May 5 and 6, 2019, one out of five registered nursing staff evening shifts was vacant with an additional one out of five registered nursing staff evening shifts vacant for half the shift;
- May 19, 2019, three out of five registered nursing staff evening shifts were vacant.

The home's "Staffing Plan Review and Evaluation" dated February 13, 2019, stated "the team evaluated the current staffing patterns in the home and made some adjustments. The adjustments were recommended according to current resident population and needs as evident with the CMI [Case Mix Index]. There was movement with current lines as well as additional lines added to meet the needs of the residents these additional hours exceed the current CMI this year." This evaluation documentation included "Assumption: minimum is one registered staff to 32 residents." (630)

C) In May 2019, the MOHLTC received complaint log #009296-19 which identified concerns from the Power of Attorney (POA) for an identified resident related to medication administration and the staffing levels in the home for registered nursing

staff.

During a follow-up interview this family member told Inspector #630 that they had general concerns with the registered nursing staff levels in the home and the provision of medications. They said they had a specific concern with the medication administration for this identified resident on a specific date in May 2019, which was related to the availability of registered nursing staff to administer medications on the evening shift. The complainant reported there was no Registered Practical Nurse (RPN) available to administer the resident's medications. They said a staff member was called in and was able to administer the 1700 hours medications, but not until 1900 hours.

The clinical record for this identified resident included documentation which showed that their medications on this specific date had not been administered at the scheduled time.

During an interview the DOCS provided a copy of the staff schedule for this specific date and shared with Inspector #563 that the evening shift had five registered staff scheduled, but there were two sick calls and one "no show" leaving two nurses left in the building. The DOCS explained that the staff member who worked day shift returned to work at 1800 hours and the staff member who was the "no show" showed up at 1900 hours. Inspector #563 and the DOCS reviewed other residents and medication times for these dates and the DOCS acknowledged there were multiple residents who had their medications administered several hours later than the prescribed time. The DOCS stated the home was already aware of the late administration times on these dates in May because of the short staffing of RPNs. (563)

D) During an interview a staff member told Inspector #689 that the home was short staffed for that evening shift and that there were only three RPNs working in the home for the four home areas. The RPN stated that they were working in two home areas on that shift. The RPN stated that there would not be a Registered Nurse (RN) in the building after management left that they knew of. When asked if they were concerned about resident safety, the RPN stated that they did not think it was safe to take care of residents on two home areas. The RPN stated that they would not complete the medications on time and there would be risk to the residents if they could not get to them to assist them. The RPN stated that they were worried about

not satisfying the needs of the residents. (689)

E) During an interview a staff member told Inspector #630 that the home had been very short for registered staff in May 2019. The staff member said that some staff had been working extra shifts or frequently working double shifts but there were still vacant shifts that were not filled. The staff member said that when there was not the full complement of registered staff in the home then the RPN from the one area would be pulled to the other area. The staff member said that during specific weekends in May 2019 the home was very short registered nursing staff and it affected medication administration. The staff member said that when there were residents who experienced a change of condition, an acute health situation or who required end of life care those became the priority for the registered nursing staff time, which made it more difficult to complete all of their other required duties. The staff member said that when a resident did require end of life care it was hard to spend the time with them that they needed. (630)

F) During an interview a staff member told Inspector #563 that an identified resident missed specific medications on a specific date in May 2019. The staff member said this resident had reported pain and that the resident stated feeling the difference when their pain medication was not administered at the time it was scheduled. The staff member stated this was not the first time residents on a unit missed an entire medication pass where the physician provided a blanket order after the incident. The staff member acknowledged that the residents in a specific area of the home were not administered their medications as prescribed at on a specific date.

In response to this interview and reference to this specific resident, progress notes were reviewed by Inspector #563. There was a progress note documented that the physician had ordered "administer 1600 medication at HS, no duplicate medications due to unforeseen circumstances." The progress notes also included "Resident did state that [they] had a noticeable difference with pain since change in pain medication, and that 1600 missed dose of analgesic did cause some minor discomfort." (563)

G) During an interview an identified resident told Inspector #615 that they usually received their medication before meals depending if there was a shortage of staff, if so they would get their medication late. This resident added that in the past an incident happened where they told the nurse that they were not feeling very good

and the nurse told them that they had to go give medication on another floor because they were short of staff and were late administrating the medication.

During an interview a staff member stated that there was two PSWs on shift that evening, that they did not have a PSW float to help and the area was short of one registered nursing staff so that nurse was covering two floors that evening.

During an interview another staff member stated that they were short of one registered nursing staff and that they had to cover two floors. This staff member added that they were overwhelmed and felt distracted.

During an interview another staff member stated that registered staff worked short and had to split the registered nursing staff to two floors to administer medication and that they have been very stressed. (615)

H) During an interview the Director of Clinical Services (DOCS) told Inspectors #630 and #689 that they were familiar with CO #002 from Inspection #2019_508137_0004 related to the home's staffing plan for personal support services and nursing support services. The DOCS said that they were involved in evaluating and revising the home's staffing plan and that the plan identified that each registered nursing staff was responsible for 26 to 28 residents maximum. The DOCS said that they did have a back-up plan to use when staff called in for their shifts and this directed that the registered staff would cover specific floors. The DOCS said that if the home was down one registered nursing staff the Two/Three North split was pulled and there was one registered staff member to cover each floor. The DOCS said if the home was down two staff then the East registered staff was to cover Two and Three East and one registered staff for Two North and another for Three North. The DOCS said that when there was not a full complement of staff the staff were expected to work together as the staff working on the North floors had 40 residents per floor. The DOCS said that there had been times in May when the home was down two or three registered staff on a shift and this tended to happen more on evenings or weekends. The DOCS said the back-up plan was provided to all staff as a resource and reviewed during staff meeting and this was reviewed and revised but was not a new model. When asked if they had identified concerns related to the completion of assessments or treatments at times when there were vacant RPN or RN shifts, the DOCS said that they had identified concerns with delays in staff completing this when the staff failed to follow the back-up plan. The DOCS said that the success of

the staffing back-up plan in meeting the care needs of the residents was variable as it depended on who was working. When asked if they had concerns regarding the staffing plan or the staffing levels in the home in May 2019, the DOCS said that they had concerns when they had staff call-ins which resulted in the home not being fully staffed. The DOCS said that when the home had the full complement of staff they had no concerns. The DOCS said that they had been recruiting and hiring new staff and thought the home would be fully staffed and would be consistently back-filling shifts within the month.

During an interview the APANS Executive Director Special Projects (EDSP) told Inspector #630 that they were familiar with CO #002 from Inspection #2019_508137_0004 and they had been involved with the implementation of the compliance action plan. When asked if, based on their involvement in the home, they had identified any concerns with the staffing levels in the home registered nursing staff or the ability of the staff to meet the care or safety needs of the residents in May, the EDSP said there had been ups and downs with the staffing. The EDSP said there had been shifts that they had not been able to cover and the home was without the full complement of registered nursing staff. The EDSP said that there had been concerns with medications not being administered on time related in part to staffing shortages.

I) During interviews the DOCS said that in response to requirements for CO #002 the staff in the home had been provided with education regarding the home's documentation policy including documentation in Point of Care (POC) and Point Click Care (PCC). The DOCS said that 88.1 per cent of the staff had completed this documentation and acknowledged that this had not met the requirements of the compliance order. The DOCS said they were continuing to work towards ensuring that all staff completed the required education.

Based on observations, interviews and record reviews the licensee has failed to ensure the written staffing plan required for the organized program of nursing services, provided for a staffing mix that was consistent with residents' assessed care and safety needs. Staff and family members identified concerns with the registered staffing levels in the home in May 2019, especially as they related to medication administration and the consistent ability of the staff the meet the care needs of the residents. The licensee failed to comply with all the requirements of CO #002 as the staffing back-up plan did not adequately address situations when staff

were could not go to work as there were multiple shifts with RN and RPN staff shortages and at times medications were not administered to residents as per use by the prescriber. The licensee also failed to ensure all nursing and personal support staff were educated on the home's documentation policy. (630) [s. 31. (3)]

The severity of this issue was determined to be a level three as there was actual risk of harm. The scope of the issue was a level two as it was a pattern. The home had a level four history as they had on-going noncompliance with this section of O. Reg 79/10 that included:
- Written Notification (WN), Compliance Order (CO) and Director's Referral (DR) issued March 11, 2019 (2019_508137_0004);
- WN, CO and DR issued November 2, 2018 (2018_607523_0026);
- WN and Voluntary Plan of Correction (VPC) issued August 1, 2018 (2018_536537_0019);
- WN and VPC issued March 29, 2017 (2017_566669_0004). (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2019_508137_0004, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with O. Reg.79/10 s.131(2).

Specifically, the licensee shall:

a) Ensure that all medications are administered to all residents in accordance for use specified by the prescriber and according to the established medication administration schedule for the home.

b) Ensure a procedure is developed for tracking and monitoring the accurate and timely administration of all scheduled medications used in the home to be implemented weekly, including who will be responsible.

c) Ensure the procedure developed and implemented weekly is analyzed and corrective action is taken as necessary and a written record is kept of everything.

d) Ensure the home's medication administration policy titled Hogan Pharmacy Partners IIAO1 – Medication Administration, General Guidelines is complied with. As specified in this policy medications are to be administered to residents within 60 minutes of the scheduled time, except time-sensitive medications which are to be administered within 30 minutes. For orders before, with or after meals medications are to be administered based on mealtimes.

e) Ensure that an interdisciplinary team, which includes the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meet to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. A written record must kept of this evaluation.

Grounds / Motifs :

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

The licensee has failed to comply with Compliance Order (CO) #005 from Inspection 2019_508137_0004 served on March 11, 2019, with a compliance due date of April

30, 2019.

The licensee was ordered to ensure that they were compliant with O. Reg. 79/10 s. 131 (2).

Specifically, the licensee was ordered to:
a) All medications are administered to all residents in accordance for use specified by the prescriber.
b) That a procedure for tracking and monitoring medication administration times is developed and implemented, including who will be responsible.
The licensee failed to complete step a) and b).

A) The Ministry of Health and Long-Term Care (MOHLTC) received complaint log #009296-19 in May 2019, where the Power of Attorney (POA) for an identified resident reported concerns with nursing/personal support services, administration of drugs, and plan of care. The complainant reported there was no Registered Practical Nurse (RPN) available to administer the resident's medications at 1700 hours on a specific date. A staff member was called in and was able to administer the 1700 hours medications, but not until 1900 hours.

The APANS Health Services-Client Service Response Form was completed in the home in response to a complaint reported by this identified resident's POA. The form documented that medication was not administered on time for a specific date as the medications were two hours late. The recommended immediate action included an order from the Medical Director at 1830 hours to administer 1600 hours medications at bedtime (HS), and no duplicate medications were to be administered.

The "Medication Admin Audit Report Afternoon Shift" for a specific area for a specific date and the electronic Medication Administration Record (eMAR) documented that specific medications had not been administered to this identified as scheduled. The progress notes included documentation on this specific date which stated "administer 1600 medication at HS, no duplicate medications due to unforeseen circumstances."

During an interview a staff member told Inspector #563 that they did recall this incident regarding the medication administration for this resident. This staff member said that on that shift none of the residents in a specific area had their medications administered at supper. The staff member stated this was very concerning because

none of the residents had received their insulin. They said they called the physician and received a "blanket order" for all residents for that area to hold their 1600 hour medications to be given at bedtime (HS) and no duplicate medications. The staff member had to review each medication to make sure doubles were not administered, and the physician's order was to also hold a specific type of insulin, therefore peripheral blood glucose (PBG) monitoring was completed to ensure those residents were "okay" since they had their supper meal and not their order for insulin at that time. The staff member stated this was not the first time residents on a unit missed an entire medication pass where the physician provided a blanket order after the incident. The staff member acknowledged that the residents on this specific area were not administered their medications as scheduled on this specific date.

In response to this staff member's interview and reference to another identified resident, the progress notes were reviewed. The progress notes included documentation on this specific date which stated "administer 1600 medication at HS, no duplicate medications due to unforeseen circumstances." The "Medication Admin Audit Report Afternoon" for a specific area for a specific date and the eMAR documented the following medications were not administered to this identified resident as scheduled.

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

B) The MOHLTC received complaint log #009293-19 in May 2019, where the anonymous complainant reported that on a specific date residents in a specific area did not receive their medications at the scheduled time. The MOHLTC also received complaint log #009454-19 where the anonymous complainant reported short staffing and medication administration concerns.

The "Medication Admin Audit Report Afternoon Shift" for a specific date and the eMAR were reviewed and two residents were selected for inspection. This showed that medications for the two residents were administered over three hours later than they had been scheduled. A specific insulin order for one of the residents was documented as "hold/see nurse notes" and was not administered.

The "Medication Admin Audit Report Afternoon Shift" for another specific date and the eMAR documented the all 0700 hour medications were administered at 0905

hours for an identified resident.

During an interview, the Director of Clinical Services (DOCS) was informed that there were multiple complaints related to the late administration of medications on in May 2019. The DOCS shared that there were two registered staff in the building on evenings to deliver medications and each nurse was covering two units. Inspector #563 asked if the "blanket" physician's order was in response to late administration of medications and the DOCS replied, "Yes". The DOCS and Inspector #563 reviewed the Medication Admin Audit Reports which showed multiple residents were administered medications including insulin and pain medications late and the DOCS acknowledged that the administration times were several hours late at times.

During an interview a staff member stated they worked specific shifts. The staff member said that on one of the shifts the PSWs on a specific area were worried that everyone needed their bedtime medications and paged the RPNs in the building to administer medications. The staff member acknowledged that medications were delivered almost two hours late on a specific date to residents in a specific area.

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

C) Inspector #563 and the DOCS reviewed other residents and medication times for two specific dates and the DOCS acknowledged multiple residents had their medications administered several hours later than the prescribed time. Time sensitive medications, including insulin, analgesics and antiparkinsonian medications were administered significantly late potentially putting the residents at risk. The "Medication Admin Audit Report" showed several medications were administered from one to four hours later than the scheduled administration time on Two East, Three East and Three North.

During an interview a staff member stated when administering medication, nurses would leave the prompt in the eMAR yellow, administer the medication and hit save to turn the medication administration green to indicate it was delivered to the resident and administered. The staff member said all medications were to be signed for at the time of administration.

The home's policy titled "Hogan Pharmacy Partners IIAO1 – Medication

Administration, General Guidelines" stated "When medications are administered from a central location, such as the medication room, medications for the immediate administration time may be prepared not more than 60 minutes in advance for all Residents, or per applicable regulation. In no case, shall more than one dose time be prepared in advance." "A schedule of routine dose administration times is established by the home and utilized on the administration records. Medications are administered within [60 minutes] of scheduled time, except Time-Sensitive Medications (e.g. anti-Parkinson's agents, anti-seizure medications, warfarin) which are administered within [30 minutes] and before, with or after meal orders, which area administered [based on mealtimes]. Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the home."

The licensee failed to ensure that medications were administered to residents on Two East, Three East and Three North in accordance with the directions for use specified by the prescriber. (563)

D) In May 2019, the MOHLTC received complaint log #010152-19 related to shortage of staff, no RN in the building and the administration of medications to residents.

A review of the home's policy # IIAO1 "Hogan Pharmacy Partners – Medication Administration, General Guidelines: stated in part "medications are administered as prescribed in accordance with good nursing principles and practices; Medications are administered in accordance with written orders of the prescriber; Medications are administered at the time they are prepared; The individual who administers the medication dose records the administration on the resident's eMAR directly after the medication is given; At the end of each medication pass, the person administering the medications reviews the eMAR to ensure necessary doses were administered and documented; If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time; the appropriate code is entered on the eMAR along with an explanation note if appropriate".

A review of the eMAR for residents on a specific date, showed identified residents did not receive their specific prescribed medications at bedtime medication pass. The eMAR for another identified resident showed they did not receive a specific prescribed medication for a 21 day period. This also showed that another identified

resident did not receive a prescribed medication for a specific period of time in May 2019. A review of the progress notes in PCC and clinical records for all the residents who did not receive their medications did not mentioned the reasons for the medication omissions or document follow-up actions.

During interviews, the DOCS acknowledged to Inspector #615 that medications were not administrated as prescribed to these identified residents and said it was the home's expectation that medications should be administrated as prescribed. (615)

E) Part b) of CO #005 from Inspection 2019_508137_0004 ordered the licensee to ensure "that a procedure for tracking and monitoring medication administration times is developed and implemented, including who will be responsible."

During an interview the Director of Clinical Services (DOCS) stated Hogan Pharmacy completed the "Medication Pass Audit" in April 2019 and the audits were due monthly. The DOCS stated this was the procedure for tracking and monitoring medication administration times and provided two Medication Pass Audits completed in April 2019. The DOCS also stated that the home's policy titled "IIIAO1: Monitoring of Medication Administration" described the procedure and who was responsible. At the time of this inspection, there were no Medication Pass Audits completed in May 2019.

The home's policy titled "Hogan Pharmacy Partners IIIAO1: Monitoring of Medication Administration policy stated, "The onsite pharmacy representative evaluates medication administration to verify that the resident has received medications in accordance with the prescriber's orders and home policy. Procedures, personnel, and techniques are monitored, and intervention is provided when necessary. Medication monitoring includes, but is not limited to, medication pass observation." The onsite pharmacy representative reviews electronic records to determine that medications are administered at the frequency and times indicated in the prescriber orders.

During an interview, Inspector #563 asked the DOCS how the times for administration were monitored and tracked to ensure residents were administered their medications in accordance for use specified by the prescriber. The DOCS then acknowledged that the audit was ineffective. The DOCS verified the audit did not monitor and track the accuracy of administration times and verified that the

"Medication Admin Audit Report" generated in PCC was not reviewed to determine accurate administration times. The acknowledged that the Medication Pass Audit did not provide the information required to monitor and track administration times as specifically outlined in CO #005.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. The licensee also failed to ensure that all components of CO #005 was completed as a procedure for tracking and monitoring medication administration times was not fully developed and implemented. (563) [s. 131. (2)]

2. The licensee failed to ensure that no resident administered a drug to himself or herself unless the administration had been approved by the prescriber in consultation with the resident.

The MOHLTC received complaint log #009296-19 in May 2019, which identified that the Power of Attorney (POA) for an identified resident reported concerns with nursing/personal support services, administration of drugs and plan of care. The complainant reported there was no Registered Practical Nurse (RPN) available to administer the resident's medications on a specific date.

During the inspection, a staff member was observed doing medication administration in a specific home area. The staff member indicated that the medication administration was later than usual but that they had two home area to complete medication administration with no one to help. The staff member was observed pouring a strip pack of medications into a medication cup and then handed the medications to an identified resident and the staff member apologized for being late. The resident was observed saying they wanted specific medications first and the staff member picked out the two pills and gave them to the resident. The resident then took the remainder of the medications in the medication cup into the dining room. The RPN did not supervise the administration of the other medications for this resident.

The plan of care for this resident did not include documentation of a physician's approval for them to self-administer a drug. The resident's profile stated "medications administered with meals in dining room" with no other documentation related to self-administration.

During an interview the staff member was asked what this resident's routine was related to the administration and they stated that the resident had a specific way that they liked to take their medications. The staff member verified that the resident did not have the approval of the physician to self administer medications and it was not included in the resident's plan of care.

During an interview the Director of Clinical Services (DOCS) verified that this resident did not have the approval of their physician to administer medications without the supervision of a nurse. The DOCS also stated that this was an unacceptable risk to other residents in the dining room.

The licensee failed to ensure that this identified resident did not administer a drug to themself unless the administration had been approved by the prescriber in consultation with the resident. (563) [s. 131. (5)]

The severity of this issue was determined to be a level two as there was minimal harm. The scope of the issue was a level three as it was widespread and had the potential to affect a large number of the home's residents. The home had a level four history as they had on-going noncompliance with this section of O. Reg.79/10 that included:
- Written Notification (WN) and Compliance Order (CO) issued March 11, 2019 (2019_508137_0004);
- WN and Voluntary Plan of Correction (VPC) issued May 28, 2018 (2018_563670_0005). (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2019(A1)

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

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

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:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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

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 11st day of July, 2019 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by AMIE GIBBS-WARD (630) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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