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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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 5, 2019	2019_559142_0014	009983-19, 010090-19	Critical Incident System

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

Garden Terrace
100 Aird Place KANATA ON K2L 4H8

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

JANET MCPARLAND (142)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 17, 23-24, 27-31, and June 3-7, 2019.

The following intakes were inspected during this Critical Incident System inspection:
-log #009983-19 Critical Incident Report (CIR) # 2882-000012-19 related to alleged staff to resident neglect
-log #010090-19 CIR #2882-000013-19 related to missing/unaccounted controlled substance

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), a Pharmacist, Clinical Care co-ordinator, RAI-MDS co-ordinator, Nursing Administration Service Manager (NASM), Directors of Care (DOCs), and the Administrator.

The inspector also observed the provision of resident care and services, including medication administration, reviewed resident health care records, including electronic medication administration records (e-MARs), Licensee medication incident reports, specific Licensee policies and procedures, and the Licensee's incident investigation notes.

The following Inspection Protocols were used during this inspection:
Medication
Prevention of Abuse, Neglect and Retaliation

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In accordance with, O.Reg. 79/10 s. 114(2), the licensee was required to 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.

Specifically, registered staff did not comply with the licensee's Blood Glucose Monitoring policy (policy #3-12-1), PRN (when necessary) Administration and Documentation policy (policy #8-4) and Individual Monitored Medication Record policy (policy #6-5).

1) Inspector #142 was provided with a copy of the licensee's contracted pharmacy's policy titled Medical Pharmacies, Blood Glucose Monitoring (policy 3-12-1). The policy outlines the procedure for performing the blood glucose test and states in procedure #7 to "record result on blood glucose monitoring log and/or equivalent".

Inspector #142 conducted interviews with registered nursing staff #101,104,105,113,116, RAI-MDS co-ordinator #102 and DOC #121 and they confirmed that blood sugars are to be documented in the e-MAR.

In review of residents #002, #015, #017, and #018 e-MARs, it was indicated to monitor residents' blood sugar at specific times. In a review of the residents' health record for identified periods of time, there was no documented entry recording residents' blood sugar in the e-MAR vital signs report for identified dates and times.

The Licensee failed to ensure that the blood glucose monitoring policy specifically related to the documentation of blood sugars was complied with.

2) Inspector #142 was provided with a copy of the licensee's contracted pharmacy's policy titled Medical Pharmacies, "PRN Administration and Documentation (policy number 8-4)". The policy indicates in procedure #4 to "Document administration on MAR sheet including: time of administration, actual dose given for orders with dosage ranges and initial in correct date column".

In interviews with DOC #121, Clinical Care co-ordinator #118, and RAI-MDS co-ordinator #102, they indicated that prn medications are to be documented on the e-MAR at the time of administration.

Residents #005, #011, #016, #017, and #019 had physician orders for specific prn (when necessary) medications. In a review of the residents' progress notes, on identified dates, RPN #100 documented that the residents were administered specific prn medications. In a review of the e-MARs, the prn medication were not documented as administered on the identified dates and times.

RAI-MDS co-ordinator #102 reviewed the e-MARs for residents #005, 011, 016 and 017 and noted that there was no documentation in the e-MARs for the administration of the medication.

The Licensee failed to ensure that the policy "PRN Administration and Documentation" was complied with specifically related to documenting the time of administration, actual dose given for orders with dosage ranges and initial in correct date column in the e-MAR.

3) Inspector #142 was provided with a copy of the licensee's contracted pharmacy's policy titled Medical Pharmacies, "Individual monitored medication record policy (policy 6 -5)". The policy states in procedure #5 to "sign on the 'individual monitored medication record' each time a dose is administered, include the date, time, amount given, amount wasted and new quantity remaining".

On a specific date, Critical Incident Report (CIR) #2882-000013-19 was submitted to MOHLTC regarding missing/unaccounted controlled substance. During the licensee's investigation, it was determined that RPN #100 did not sign for the narcotics on the

narcotic sign out sheet for four residents, however they signed the medication as administered on the e-MARs.
Residents #001, #002, #003, and #004 had a physician order for specific medications.
In review of the monitored medication record for residents #001, 002, 003, and 004 it was noted that RPN #100 did not sign on the individual monitored medication records for the administration of the controlled substances which were scheduled to be administered on a specific date and time. Inspector #142 conducted an interview with RPN #113 and #106, and they indicated they conducted a shift change monitored medication count on a specific date and the shift change monitored medication count was correct.

In interviews with Inspector # 142, registered nursing staff # 104,105,113,114, and 116 indicated that when administering a controlled substance, they are to sign on the individual monitored medication record each time a dose is administered.

The licensee failed to ensure that the policy “Individual monitored medication record policy” was complied with specifically related to the signing on the individual monitored medication record each time a dose is administered, include the date, time, amount given, amount wasted and new quantity remaining for residents #001, 002, 003, and 004. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1.The licensee has failed to ensure that drugs were administered to residents on a specific resident home area on specific dates in accordance with the directions for use

specified by the prescriber.

On a specific date, a Critical Incident Report (CIR) #2882-000012-19 was submitted to the MOHLTC regarding an allegation of staff to resident neglect. In the CIR report, it was noted that on a specific date, medications were not administered to residents on a specific resident home area.

During an interview with Inspector #142, PSW #108 indicated that they observed RPN #100 at the medication cart, in a specific resident home area (RHA). PSW #108 was feeding residents and did not observe RPN #100 administer medications by mouth to residents. Furthermore, the PSW indicated that they did not see or hear the RPN crushing residents' medications.

During interviews with Inspector #142, the Clinical Care co-ordinator #118 and NASM #119 both indicated that they entered the medication room on a specific RHA, and observed several whole medications disposed of in the garbage bag.

In additional interviews with DOC #121, Pharmacist #103 and the Administrator, they all confirmed that, on a specific date, they observed several whole medications disposed of in the garbage bag which had been retrieved from the medication cart.

Inspector #142 conducted observations of the morning medication administration to residents of a specific resident home area. It was noted that several residents required their medication crushed. In an interview with RPN #113, the permanent fulltime RPN for the RHA, they indicated that the majority of residents require their medications crushed and receive their morning medications in the dining room during breakfast.

Inspector #142 reviewed the licensee's medication incident reports for an identified timeframe.

Resident #023, 024, and 025 were to receive specific medications on a specific date and time. On a specific date, RPN #123 found, in the medication cart, the medications that were scheduled to be administered for a specified date and time. In residents' progress notes, RPN #100 indicated that residents medications were held.

The Licensee failed to ensure that residents on a specific resident home area, and residents #023, 024, and 025 received their medication in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving residents #023, 024 and 025 were (b) reported to the residents' substitute decision makers (SDMs), and the residents' attending physician.

Inspector #142 reviewed the licensee's medication incident reports for an identified timeframe.

As identified in WN # 2, on a specific date, RPN #123 found, in the medication cart, the medications which were scheduled to be administered to residents #023, #024 and #025 for a specified date and time.

In a review of the medication incident reports, there was no indication that the medication incident reports were reported to the residents' SDMs, or the residents' attending physician. In addition, the residents' health records were reviewed and there were no progress notes indicating that the SDMs or attending physician were notified.
In interviews with RPN #123 and Clinical Care co-ordinator #118, they indicated that the notification of the SDM and physician should be documented on the medication incident report.
The licensee failed to ensure that the medication incidents related to resident #023, 024, and 025 were reported to the residents' SDMs and attending physician. [s. 135. (1)]

Issued on this 15th day of July, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JANET MCPARLAND (142)
Inspection No. / No de l'inspection :	2019_559142_0014
Log No. / No de registre :	009983-19, 010090-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 5, 2019
Licensee / Titulaire de permis :	0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership 2020 Fisher Drive, Suite 1, PETERBOROUGH, ON, K9J-6X6
LTC Home / Foyer de SLD :	Garden Terrace 100 Aird Place, KANATA, ON, K2L-4H8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Christine Schyf

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 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership, you are hereby required to comply with the following order(s) by the date (s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 ensure that registered nursing staff comply with the licensee's Blood Glucose Monitoring policy and PRN Administration and Documentation policy.

In addition the licensee shall:
1) educate registered nursing staff on the licensee's policies related to blood glucose monitoring and prn medication administration and documentation.

2) conduct weekly audits on all three shifts for a period of 4 consecutive weeks, and take corrective action if deviations from the licensee's policies and procedures related to blood glucose monitoring and prn medication administration and documentation are identified.

3) A written record must kept of all actions taken in response to steps 1 and 2.

Grounds / Motifs :

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

In accordance with, O.Reg. 79/10 s. 114(2), the licensee was required to 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.

Specifically, registered staff did not comply with the licensee's Blood Glucose Monitoring policy (policy #3-12-1), and PRN (when necessary) Administration and Documentation policy (policy #8-4).

1) Inspector #142 was provided with a copy of the licensee's contracted pharmacy's policy titled Medical Pharmacies, Blood Glucose Monitoring (policy 3 -12-1). The policy outlines the procedure for performing the blood glucose test and states in procedure #7 to "record result on blood glucose monitoring log and/or equivalent".

Inspector #142 conducted interviews with registered nursing staff #101,104,105,113,116, RAI-MDS co-ordinator #102 and DOC #121 and they confirmed that blood sugars are to be documented in the e-MAR.

In review of residents #002, #015, #017, and #018 e-MARs, it was indicated to monitor residents' blood sugar at specific times. In a review of the residents' health record for identified periods of time, there was no documented entry recording residents' blood sugar in the e-MAR vital signs report for identified dates and times.

The Licensee failed to ensure that the blood glucose monitoring policy specifically related to the documentation of blood sugars was complied with.

2) Inspector #142 was provided with a copy of the licensee's contracted pharmacy's policy titled Medical Pharmacies, "PRN Administration and Documentation (policy number 8-4)". The policy indicates in procedure #4 to "Document administration on MAR sheet including: time of administration, actual dose given for orders with dosage ranges and initial in correct date column".

In interviews with DOC #121, Clinical Care co-ordinator #118, and RAI-MDS co-ordinator #102, they indicated that prn medications are to be documented on the

e-MAR at the time of administration.

Residents #005, #011, #016, #017, and #019 had physician orders for specific prn (when necessary) medications. In a review of the residents' progress notes, on identified dates, RPN #100 documented that the residents were administered specific prn medications. In a review of the e-MARs, the prn medication were not documented as administered on the identified dates and times.

RAI-MDS co-ordinator #102 reviewed the e-MARs for residents #005, 011, 016 and 017 and noted that there was no documentation in the e-MARs for the administration of the medication.

The Licensee failed to ensure that the policy "PRN Administration and Documentation" was complied with specifically related to documenting the time of administration, actual dose given for orders with dosage ranges and initial in correct date column in the e-MAR.

The severity of this issue was determined to be a level 2, potential for actual harm/risk. The scope of the issue was determined to be widespread. The Licensee had a history of non-compliance under O.Reg. 79/10 s. 8 (1)(b) that included a written notification being issued on July 13, 2017 (2017_582548_0008)

(142)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l’article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l’ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l’ordre qui font l’objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l’adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 5th day of July, 2019

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : JANET MCPARLAND

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