Ministry of Health and Long-Term Care
Long-Term Care Homes Division
Long-Term Care Inspections Branch

Ministère de la Santé et des Soins de longue durée
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ **Licensee Copy/Copie du Titulaire** ✕ **Public Copy/Copie Public**
Name of Director:	Wendy Lewis
Order Type:	☐ Amend or Impose Conditions on Licence Order, section 104 ☐ Renovation of Municipal Home Order, section 135 ✕ Compliance Order, section 153 ☐ Work and Activity Order, section 154 ☐ Return of Funding Order, section 155 ☐ Mandatory Management Order, section 156 ☐ Revocation of License Order, section 157 ☐ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	005175-18
Original Inspection #:	2018_610633_0005
Licensee:	Golden Years Nursing Homes (Cambridge) Inc. 704 Eagle Street North, P.O. Box 3277, CAMBRIDGE, ON, N3H-4T3
LTC Home:	Golden Years Nursing Home 704 Eagle Street North, P.O. Box 3277, CAMBRIDGE, ON, N3H-4T3
Name of Administrator:	Danny Pereira

Background:

Ministry of Health and Long-term Care (MOHLTC) Inspector #633 conducted an inspection of Golden Years Nursing Home on March 26, 27, 28 and 29, 2018. (2018_610633_0005). The inspection was a Complaint inspection at which time intake log # 005175-18 was inspected.

During the inspection, Inspector #633 found that the Licensee, Golden Years Nursing Home (Cambridge) Inc. or the Licensee) failed to comply with certain provisions (as identified below) of the Long-Term Care Homes Act, 2007 (LTCHA) and Regulation and issued Compliance Order #001.

Pursuant to s. 153 (1)(a) of the LTCHA, Inspector #633, issued the following:

Compliance Order #001 relates to Ontario Regulation 79/10 s.114 (1) and reads as follows:
The licensee must be compliant with O. Reg. 79/10, s. 114 (1).

1. Specifically the licensee must complete a comprehensive review of the medication management system and the home's related policies that includes:
-Medication reconciliation on admission related to Parkinson's disease medication management and substitute decision maker (SDM) involvement.
-The best practices from the Institute for Safe Medication Practices (ISMP) related to medication reconciliation and Parkinson's disease medication administration.

This review must be documented and include the date of the review, who attended, what changes were made and when these changes were implemented.

2. Ensure that resident #002 and #003 and all residents with Parkinson's disease receive their scheduled Parkinson's medications as prescribed and according to best practices.

3. Direct all nursing staff to review the College of Nurses of Ontario (CNO) Medication Practice Standards at http://www.cno.org/globalassets/docs/prac/41007_medication.pdf and http://www.cno.org/en/learn-about-standards-guidelines/educational-tools/decision- tool-medication/ and the best practices from (ISMP) related Parkinson's disease medication administration. All registered staff must sign off on their review.

This order must be complied by: May 23, 2018

In my analysis of the Licensee's submissions and in making my decision, I reviewed the Inspector's evidence and grounds for the compliance order, and considered the following provisions of the LTCHA and Regulation:
Plan of Care
Based on assessment of resident
6 (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.
Involvement of resident, etc.
6 (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The home did have a medication management system in place for residents admitted to the home, however based on the evidence, this process did not provide safe medication management and optimize the effective drug therapy for resident #001, and as a result this finding should be issued under s.6 (2) & (5) rather than under s.114 of the LTCHA. The resident did not receive his Parkinson's medication on time as per his medical needs and preferences, nor was the resident or SDM given an opportunity to participate fully in the development and implementation of the resident's plan of care.
Further, interventions in place at the time were not effective and the resident should have been assessed for the use of bed rails and had a plan of care based on that assessment.
The Licensee has an obligation to meet the requirements of the LTCHA and Regulation and did not ensure that the care set out in the plan of care was based on an assessment and the needs and preferences of resident #001. Additionally, the Licensee did not ensure that the SDM for resident #001 and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of resident #001's plan of care. Accordingly, I am altering the Inspector's Order and substituting it with a Director's Order.

Order #:	001

To **Golden Years Nursing Homes (Cambridge) Inc.**, you are hereby required to comply with the following order by the date set out below:

Pursuant To:

LTCHA, 2007, s. 6. Plan of care

Order:

Director's Order #001 is being made pursuant to section 153(1)(a) of the LTCHA.

The Licensee must be compliant with LTCHA s. 6 (2) & (5).

1. The Licensee must revise the medication reconciliation process in the home to ensure that the resident and/or SDM are given an opportunity to fully participate in the plan of care.

2. Ensure that each resident with Parkinson's disease receives their medication according to administration times specific to their as per their individual medical needs and preferences.

3. Educate all medical staff in the home regarding best practices as identified by the Institute for Safe Medication Practices (ISMP) related to Parkinson's disease medication administration and potential outcomes that may occur if the residents do not receive their medication on time as per their schedule.

4. Educate registered nursing staff regarding the importance of critical thinking using the College of Nurses of Ontario (CNO) Practice Standard titled "Medication", revised 2007, "Decision Tree: Deciding About Medication Administration" and "Medication Decision Tool"

5. Ensure that all residents at risk of falls receives a bed rail assessment when other alternatives have not been effective.

This order must be complied with by: July 20, 2018

Grounds:

1. The Licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.
A complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) on March 2, 2018, from the Substitute Decision Maker (SDM) of resident #001. The complaint intake and supporting documents stated that the home did not adhere to resident #001's basic need of receiving their Parkinson's disease medications on time.
Resident #001 was admitted to the home on September 14, 2017 with a diagnosis of Parkinson's disease. He fell 26 times in the two months that he resided in the home. 13 of those falls were due to rolling out of bed. His final fall in the home on November 16, 2017 resulted in his death from a head injury.

The Pharmacist stated in an interview that the sources used for medication reconciliation were hospital discharge notes if applicable and the community pharmacy and they confirmed that Substitute Decision Makers (SDM's) were not part of the resident's medication reconciliation process. They further stated that they usually considered the other sources as a more reliable source of information than the SDM and this was the normal and expected practice.
The Physician responsible for resident #001's medical care also confirmed this practice and stated that they were aware of the recommendations made by the resident's specialist related to administering their Parkinson's medications on time. The Physician explained that Parkinson's medications were given more than other medications and at specific times to manage symptoms. They also stated that administering these medications half an hour early or late of the scheduled time may cause symptoms of drowsiness, weakness and falling.
The Institute for Safe Medication Practices (ISMP) defines medication reconciliation as a formal process in which healthcare providers work together

with patients to ensure accurate and comprehensive medication information is communicated consistently across transitions of care. There is no documentation to support that the resident or SDM was involved in a collaborative way. The fact that the SDM provided a list of medications for consideration does not constitute working together to ensure accurate and comprehensive medication information is communicated consistently across transitions of care.
ISMP also defines Best Possible Medication Process as “a complete and accurate list of all the medications a patient is taking created using at least 2 reliable sources of information including a client and or family interview.” This also did not happen as confirmed by the Inspector during interviews conducted during the inspection.
The SDM spoke to numerous staff, the Physician, the Assistant Director of Care as well as the Director of Care about the fact that it was extremely important that the resident follow the same medication administration schedule as he did at home. This was based on the resident’s needs as confirmed by the neurologist treating him for his Parkinson’s disease and the Movement Disorders Centre.
Two letters were sent to the home by specialists in movement disorders stressing the importance of following the individualized medication administration schedule for resident #001 in order to maintain proper mobility as well as his safety. They also noted a significant decline in the resident’s condition since his admission to the home.
The Physician when asked by the Inspector stated that they were aware of the recommendations made by the resident’s specialist related to administering their Parkinson’s medications on time. The Physician explained that Parkinson’s medications were given more than other medications and at specific times to manage symptoms. They also stated that administering these medications half an hour early or late of the scheduled time may cause symptoms of drowsiness, weakness and falling.
The Pharmacist was asked by the Licensee to conduct a medication review in March of 2018 following a complaint received by the home in March 2018 from the SDM. The report indicated that “Ferrous Fumarate 300 milligrams twice daily at 1200 ad 2100 hours would result in decreased Sinemet absorption and this medication would need to be separated by at least two hours”. The case review also stated that the Sinemet dosing was appropriate however “the scheduling may have been difficult to maintain for the registered staff, leading to suboptimal outcomes”. It was also noted that the resident was receiving an antipsychotic medication Quetiapine with no diagnosis in the chart to support its use for this resident. A side effect of this medication is restless legs which as the licensee submits could have contributed to resident #001’s falls.
The Medication Administration Record (MAR) for resident #001 identified that from September 18, 2017 to November 16, 2017, (60 days) Sinemet tablet 100-25 mg (Levodopa-Carbidopa) was scheduled five times a day and Sinemet CR 200/50 tablet Extended Release (Levodopa-Carbidopa ER) once a day for the symptom management of Parkinson’s disease. Ferrous Fumarate 300mg was increased to twice daily on October 10, 2017. An audit report of the MAR stated that the Sinemet administration times, on all shifts by multiple registered staff, were sporadically administered to resident #001 and 42 doses were not given within an hour before or after the scheduled physician’s orders. This audit report also stated that on 82 different occasions, Ferrous Fumarate was given to resident #001 either along with or within two hours of resident #001’s Sinemet administration.
The Physician said that resident #001’s scheduled medications, six times daily was not impossible however this would take effort by the staff and may have been difficult for staff to maintain at the home.
When the SDM spoke to the ADOC about her concerns she was told that they could not give the resident special treatment by giving him his medications outside of the home’s policy for medication administration times.
During interviews with the nursing staff it was evident that they were not aware of the importance of providing the Parkinson’s medication at the times prescribed specifically for this resident’s condition and continued to state that

they had one hour before and after the resident's administration time to give the medication. This is despite the concerns expressed by the resident, SDM and the specialists from the Movement Disorders Clinic.
Resident #002 and resident #003 had a diagnosis of Parkinson's disease and their MAR identified the following:
• The MAR for resident #002 indicated that between February 28, 2018 and March 29, 2018 they did not receive their Levodopa-Carbidopa tablet on four occasions within the one hour window before or after the scheduled administration time.
• The MAR for resident #003 indicated that between February 28, 2018 and March 29, 2018 they did not receive their Levodopa-Carbidopa tablet on 44 occasions within the one hour window before or after the scheduled administration time.

2.In the Licensee's submission they provided the following documents titled:

a. Clinical Guideline for the Assessment end Implementation of Bed rails in Hospitals, Long Term Care facilities and Home Care Settings: developed by the Hospital Bed Safety Workgroup.
b. "Rethinking bedrail safety': Long Term Care TODAY, Volume 26, Issue 3.

The home's policy "005530.00 Bed Rails (Siderails)" indicated that all residents being admitted to the home after April 1, 2015 will not utilize bedrails upon admission to the home and that bedrails will only be considered for resident mobility. If the physiotherapist and other members of the interdisciplinary team find the side rail to be a consideration for mobility or transfer they will institute an assessment process.

That the resident will be assessed for alternative devices for mobility or transfer.
That if there are no other alternatives a bed assessment will be completed in PCC.
That if the resident passes the assessment, side rails can be implemented into the plan of care.
That the bed rail will remain if the resident meets the criteria, if the resident does not meet the criteria for a bed rail the plan of care will be updated and the resident/SDM will be notified".

The SDM indicated that within the first week of the resident's admission she was told that the handbook for the home says bed rails are not allowed in the home. They could be used if assessed by the physiotherapist.
She indicated to staff that the resident had one bed rail at home which allowed him to move in bed and would assist him with swinging his legs to get out of bed.
The resident was at high risk for falls and a history of falls prior to admission to the home. During the two months the resident lived in the home, he had a total of 26 falls, 13 of which were caused by rolling out of bed. When asked about alternatives to bed rails the Physiotherapist suggested that a transfer pole may have assisted him with transferring in and out of bed. The Physiotherapist confirmed that there was no assessment by the Occupational Therapist related to bed transfer, safety or bed rails for resident #001.
The home implemented a policy on April 1, 2015 to ensure that residents in the home are protected from the hazards associated with bed rail use. The issue is that the policy also indicates that should a resident require bed rails for positioning and safety, they would receive an assessment.
The application of factors taken into account under section 299(1) of Ontario Regulation 79/10, requires a Compliance Order to be issued. The severity of the issues in that the issues are related to not providing care based on the medical needs of resident #001 and could have resulted in potential or actual harm to the resident . The scope is a pattern in that there were 2 out of 3 residents with Parkinson's disease whose needs were not being met regarding the administration time of their medication. The Licensee has a previous

compliance history relating to this specific provision.

This order must be complied with by:	July 20, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
1075 Bay St., 11th Floor, Suite 1100
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.

Issued on this 26th day of June, 2018	
Signature of Director:	
Name of Director:	Wendy Lewis