Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
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Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 3, 2017	2017_577611_0003	024898-16, 027650-16, 004258-17	Critical Incident System

Licensee/Titulaire de permis

DEEM MANAGEMENT SERVICES LIMITED
2 QUEEN STREET EAST SUITE 1500 TORONTO ON M5C 3G5

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

HAMILTON CONTINUING CARE
125 WENTWORTH STREET SOUTH HAMILTON ON L8N 2Z1

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

KELLY CHUCKRY (611)

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): February 24, 27, and 28, 2017.

During the course of this inspection the inspector observed the provision of resident care, reviewed applicable clinical health records, policies, procedures, practices, and investigation notes. Three Critical Incident inspections were inspected upon during this inspection including Log #024898-16 related to responsive behaviours, Log #027650 related to falls prevention, and Log #004258-17 related to medication management. In addition, one follow up inspection was conducted concurrently with this inspection. Log #031607-16 related to the prevention of abuse and neglect, that is documented on report # 2017_577611_0004.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, registered staff, Personal Support Workers (PSWs), housekeeping staff and residents.

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by, or administered to a resident in the home, unless the drug was prescribed for the resident.

On an identified date, staff #100 was the registered staff member assigned to the medication administration pass during an identified shift. During the medication pass for resident #005, staff #100 prepared the medication for administration by placing them in a medication cup in order to administer the medication to resident #005. The staff member then took the medication cart and the pre-poured medication to the room of resident #005. At this time, staff #100 noticed that this resident was asleep and not ready to receive the morning medications.

Staff #100 proceeded to prepare the medication for administration for resident #006. During this time, the medication for resident #005 remained on the medication cart, and was not immediately administered to this resident.

Resident #005 was administered the wrong medication. Resident #005 suffered side effects from this medication administration and required a transfer to hospital for assessment and treatment. A diagnostic test conducted for resident #005 confirmed the administration of the medication that was not ordered by the physician.

In an interview conducted with staff #100, and a subsequent interview conducted with the Administrator/Director of Care, it was acknowledged that resident #005 was administered medications that were not prescribed for them. [s. 131. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 failed to ensure that any plan, policy, protocol, procedure, strategy, or system instituted or otherwise put in place was complied with.

The home's policy, The Medication Pass (3-6), outlined the procedure for the medication pass to be followed by registered staff. Under the procedure, the second paragraph indicated that registered staff were to ensure that the resident was ready to take the medications. Once the registered staff member ensured the resident was ready to take the medication, the policy further directed the process for the medication pass. This included finding the Medication Administration Record (MAR) for the resident and identifying the medication pass, locating the medication for the resident, checking each medication label against the MAR to ensure accuracy, and to prepare the medications.

On an identified date, staff #100 was the registered staff member assigned to the medication administration pass during an identified shift. During the medication pass for resident #005, staff #100 prepared the medication for administration by placing them in a medication cup in order to administer the medication to resident #005. The staff member then took the medication cart and the pre-poured medication to the room of resident #005. At this time, staff #100 noticed that this resident was asleep and not ready to receive the morning medications.

Staff #100 proceeded to prepare the medication for administration for resident #006. During this time, the medication for resident #005 remained on the medication cart, and was not immediately administered to this resident.

As a result of the policy not being complied with, resident #005 was administered the wrong medication. Resident #005 suffered side effects from this medication

administration and required a transfer to hospital for assessment and treatment. A diagnostic test conducted for resident #005 confirmed the administration of the medication that was not ordered by the physician.

In an interview conducted with staff #100, and a subsequent interview conducted with the Administrator/Director of Care, it was acknowledged that resident #005 was administered medications that were not prescribed for them, and the above noted policy was not complied with.

In accordance with s. 114 (1) every licensee if required to ensure that all staff comply with an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy, or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The license failed to ensure that drugs remained in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

On an identified date, staff #100 was the registered staff member assigned to the medication administration pass during an identified shift. During the medication pass for resident #005, staff #100 prepared the medication for administration by placing them in a medication cup in order to administer the medication to resident #005. The staff member then took the medication cart and the pre-poured medication to the room of resident #005. At this time, staff #100 noticed that this resident was asleep and not ready to receive the morning medications.

Staff #100 proceeded to prepare the medication for administration for resident #006. During this time, the medication for resident #005 remained on the medication cart, and was not immediately administered to this resident.

Resident #005 was administered the wrong medication. Resident #005 suffered side effects from this medication administration and required a transfer to hospital for assessment and treatment. A diagnostic test conducted for resident #005 confirmed the administration of the medication that was not ordered by the physician.

In an interview conducted with staff #100 and a subsequent interview conducted with the Administrator/Director of Care, it was acknowledged that the medication for resident #005 was not kept in the original, labelled packaging provided by the pharmacy until administered to the resident. [s. 126.]

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 remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of a medication incident or adverse drug reaction in respect of which a resident was taken to hospital within one business day of the occurrence of the incident.

On an identified date, staff #100 was the registered staff member assigned to the medication administration pass during an identified shift. During the medication pass for resident #005, staff #100 prepared the medication for administration by placing them in a medication cup in order to administer the medication to resident #005. The staff member then took the medication cart and the pre-poured medication to the room of resident #005. At this time, staff #100 noticed that this resident was asleep and not ready to receive the morning medications.

Staff #100 proceeded to prepare the medication for administration for resident #006. During this time, the medication for resident #005 remained on the medication cart, and was not immediately administered to this resident.

Resident #005 was administered the wrong medication. Resident #005 suffered side effects from this medication administration and required a transfer to hospital for assessment and treatment. A diagnostic test conducted for resident #005 confirmed the administration of the medication that was not ordered by the physician.

On February 21, 2017, a Critical Incident Report was submitted to the Ministry of Health and Long Term care, outlining the details of the medication incident, including transfer to hospital.

In an interview, the Administrator/Director of Care acknowledged that this Critical Incident Report was submitted in excess of one business day following the incident. [s. 107. (3) 5.]

Issued on this 4th day of April, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY CHUCKRY (611)
Inspection No. / No de l'inspection :	2017_577611_0003
Log No. / Registre no:	024898-16, 027650-16, 004258-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 3, 2017
Licensee / Titulaire de permis :	DEEM MANAGEMENT SERVICES LIMITED 2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5
LTC Home / Foyer de SLD :	HAMILTON CONTINUING CARE 125 WENTWORTH STREET SOUTH, HAMILTON, ON, L8N-2Z1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Enesia Malapela

To DEEM MANAGEMENT SERVICES LIMITED, 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) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

The plan shall include
a) strategies to ensure that all residents receive medications as prescribed
b) registered staff education on safe medication management practices including education on all policies related to medication management, including dates that the education will be completed and c) quality management activities (including the type of activities and frequency) that will be implemented to target the specific area of non-compliance.

The plan should be submitted via email by April 13, 2017 to Kelly Chuckry at the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 119 King St. W, 11th floor, Hamilton, ON L8P 4Y7 HamiltonSAO.MOH@ontario.ca

Grounds / Motifs :

1. This Order is made based on the application of the factors of severity (3), scope (1), and compliance history (2).

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

On an identified date, staff #100 was the registered staff member assigned to the medication administration pass during an identified shift. During the medication pass for resident #005, staff #100 prepared the medication for administration by placing them in a medication cup in order to administer the medication to resident #005. The staff member then took the medication cart and the pre-poured medication to the room of resident #005. At this time, staff #100 noticed that this resident was asleep and not ready to receive the morning medications.

Staff #100 proceeded to prepare the medication for administration for resident #006. During this time, the medication for resident #005 remained on the medication cart, and was not immediately administered to this resident.

Resident #005 was administered the wrong medication. Resident #005 suffered side effects from this medication administration and required a transfer to hospital for assessment and treatment. A diagnostic test conducted for resident #005 confirmed the administration of the medication that was not ordered by the physician.

In an interview conducted with staff #100, and a subsequent interview conducted with the Administrator/Director of Care, it was acknowledged that resident #005 was administered medications that were not prescribed for them. (611)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 01, 2017

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 3rd day of April, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Chuckry

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