Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 20, 2018;	2018_597655_0013 (A1)	009583-18	Resident Quality Inspection

Licensee/Titulaire de permis

Villa Marconi Long Term Care Center
1026 Baseline Road OTTAWA ON K2C 0A6

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

Villa Marconi
1026 Baseline Road OTTAWA ON K2C 0A6

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

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Rapport d’inspection prévue le Loi de 2007 les foyers de soins de longue durée

Amended by MICHELLE EDWARDS (655) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

On September 14, 2018, the home's Administrator requested an extension for compliance orders #001 and #002 to have their compliance due dates changed to November 7, 2018, to accommodate the training of all staff as it relates to these compliance orders. The request was approved.

Issued on this 20 day of September 2018 (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 MICHELLE EDWARDS (655) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): May 28, 29, 30, and 31, 2018; and, June 1, 4, 5, 6, 7, 11, 12, 13, 15, 18, 19, 20, 21, 22, 29, 2018, on-site. The inspection was conducted off-site on June 27 and 28, 2018; and August 1, 2 and 30, 2018.

The following intakes were completed during this inspection:

- Log #'s 011137-17, and 027412-17, critical incidents, each related to a fall that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's condition,

- Log # 026601-17, a critical incident also related to falls as well as responsive behaviours,

- Log # 004695-18, a critical incident related to an environmental hazard involving the failure or breakdown of major equipment (generator),

- Log # 005293-18, a complaint related to falls, restorative care, responsive behaviours, failure or breakdown of major equipment (generator), and emergency plans,

- Log # 002455-18, a follow-up related to responsive behaviours,

- Log # 008231-18, a complaint related to plan of care, nutrition and hydration, skin and wound, and alleged neglect,

- Log # 011039-18, a critical incident related to the improper treatment of a

resident that resulted in harm; and,

- Log # 021641-17, a critical incident related to a missing or unaccounted for controlled substance.

During the course of the inspection, the inspector(s) spoke with residents and family members, personal support workers (PSWs), registered practical nurses (RPNs), registered nurses (RN), the Volunteer Coordinator, the Recreation Coordinator, a Dietary Aide, the Resident Care and Informatics Manager, Director of Resident Services, environmental staff, the Environmental Supervisor, the Director of Care (DOC), the Assistant Pharmacy Manager, the Pharmacist Consultant, the Physiotherapist, the Dietician, and the Administrator.

During the inspection, the inspectors also observed the provision of care and services to residents, reviewed resident health care records, relevant policies and procedures, internal medication incident reports, internal investigation notes, and relevant meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **13 WN(s)**
- **3 VPC(s)**
- **4 CO(s)**
- **3 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. 55.	CO #001	2018_584161_0001	593

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
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 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 the home's policy titled "Pain and Symptom Management" (Policy Number LTC-RCM-G-30.10), dated January, 2015, was complied with.

In accordance with section 30 (1) of Ontario Regulation 79/10, every licensee of a long-term care home shall ensure that for each of the interdisciplinary programs required under section 48 of the regulation, there is a written description of the program that includes relevant policies, procedures and protocols.

In accordance with section 48 (1) of Ontario Regulation 79/10, every licensee of a long-term care home shall ensure that a pain management program is developed and implemented in the home in order to identify and manage residents' pain.

A review of the home's policy titled "Pain and Symptom Management" (policy number LTC-RCM-G-30.10), dated January, 2015, found that the registered nursing staff will conduct and document a pain assessment electronically: On admission, re-admission, quarterly and annually; and when requiring three or more breakthrough doses of pain medication for greater than 24 hours.

During stage one of the Resident Quality Inspection (RQI), residents #001, #003 and #019 reported that they experienced chronic pain.

A review of resident #001's progress notes from over a one month period found numerous entries related to resident #001 complaining of pain and requiring a PRN for pain management. Resident #001's e-Assessments in Med e-Care were reviewed and the last completed pain assessment was from over a year ago.

A review of resident #019's care plan, found that resident #019 had pain related to specified medical conditions. Resident #019's e-Assessments in Med e-Care were reviewed and the last completed pain assessment. The most recent assessment found was from a specified month in 2018; and, the one prior to this was from over a year ago.

A review of resident #003's care plan, found that resident #003 had pain in specific areas of the body related to a medical condition. In resident #003's plan of care, orders for both routine and "PRN" (as needed) medications were found. The inspector reviewed resident #003's Medication Administration Records (MARs) for five separate months. According to resident #003's Medication Administration Records (MARs), resident #003 was given a specified PRN medication for pain 23 times in the first month, 20 times in the second month, 14 times in the third month, 8 times in the fourth month; and, once in the fifth month.

A review of resident #003's progress notes found numerous entries over a period of four months related to resident #003 complaining of pain, and requiring a PRN medication for pain management. Resident #003's e-Assessments in Med e-Care were reviewed and the last completed pain assessment was from over a year ago.

During an interview with Inspector #593, resident #003 reported that they had very bad pain and recently it had been getting worse. Resident #003 further added that they were given the above-noted specified medication for the pain "but it doesn't help much, I am still in pain".

During an interview with Inspector #593, RPN #106 reported that pain assessments are completed as needed; however, there was a new schedule they were to follow now and they were to complete a quarterly pain assessment for each resident. The RPN said that the new assessment schedule was posted on the Med e-Care home screen. Inspector #593 reviewed what was posted on the Med e-Care home screen and found that "Pain" assessments were scheduled to be completed in the months of January, April, July, and October (or, on a quarterly basis).

During an interview with Inspector #593, RN #107 reported that resident #003 had pain related to a specific medical condition. The RN checked the resident's chart and was unable to locate a completed pain assessment for resident #003 that was more recent than the above-noted assessment completed over a year ago. RN

#107 reported that these pain assessments should be completed for all residents every three or six months by the RPNs on the units. There was an assessment schedule and the pain assessments, as per the schedule, were supposed to be completed in May, 2018. The RN further added that a pain assessment would also be completed for residents experiencing chronic pain that wasn't managed by their regular prescribed medications.

During a second interview with Inspector #593, RN #107 reported that there was no time limit on the pain assessments, they would be completed when a resident started to ask for more PRN medication for breakthrough pain. The RN was not aware of the PRN medication usage for this resident. However, when they reviewed the the resident's MAR for a specified month, the RN's response was "I guess we will complete a pain assessment then".

During an interview with Inspector #593, Resident Care and Informatics Manager (RCIM) #109 reported that based on the home's policies and procedure, a pain assessment should be completed upon admission, readmission, any significant change, if pain medications are given and not effective, if there is an increase in the use of PRN medication for breakthrough pain or if the residents pain scale is over two. They also have to complete quarterly pain assessments for all residents and this schedule was posted on the Med e-Care home page.

Contrary to the home's policy titled "Pain and Symptom Management" (Policy number LTC-RCM-G-30.10), dated January, 2015, there was no quarterly pain assessments completed for residents #001, #003 and #019 and despite resident #003 reporting an increase in pain which was supported by progress notes and an increase in PRN medication for pain management, a pain assessment for resident #003 had not been completed in over a year. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that policies related to the medication management system were complied with.

In accordance with Ontario Regulation 79/10, s. 114 (2), the licensee was required to have written policies and protocols 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.

1. Medication Reconciliation

Specifically, the licensee has failed to ensure that the following policies and protocols related to medication reconciliation were complied with:

- "Medication Reconciliation" (Policy Number LTC-NAM-F-10.40), effective January, 2015,
- "Medication Reconciliation – Long Term Care Homes Using Med e-Care" (Policy Number 9.6); and,
- "Medication Reconciliation- Long Term Care Homes" (Policy Number 2.7.1), revised December, 2016.

Inspector #655 reviewed all three of the above-identified policies related to medication reconciliation; and, over the course of the inspection reviewed the medication reconciliation process with RN #107, a pharmacy representative, DOC #124 and Director of Resident Services #113.

According to the licensee's policies, the medication reconciliation process includes the following steps:

- The nurse is to create a best possible medication history (BPMH) from all possible sources, during which time the resident and/or resident's family would be interviewed.
- The nurse is to document the BPMH obtained in the spaces provided on the Medication Reconciliation and Admission Order (MEDREC) form, indicating for each medication: the medication name, strength, dose, route of administration, frequency, and indication for use, if known at the time of admission from a reliable medical source.
- The nurse is to identify all relevant sources used to create the BPMH from the list of options that are provided in the upper right-hand corner of the MEDREC form.
- Various orders are to be compared while monitoring for any discrepancies. When there is a discrepancy, the nurse is to document the details of the discrepancy in the comments section next to the medication order on the MEDREC form; resolve identified discrepancies with the most appropriate health care professional, document the resolution details on the form, and make any necessary adjustments to the medication orders.
- The MEDREC form is then to be signed and dated by the nurse who is responsible for preparing the form; and the resident's attending physician is contacted.
- The physician assesses the nurse prepared medication profile as recorded on the MEDREC form (and any supporting documents as applicable); and then provides

direction to "continue", "discontinue", or "hold" each listed medications. This is to be documented on the MEDREC form first by checking the appropriate box ("continue", "discontinue", "hold") for each order.
- For risk management purposes, the nurse is then required to clearly cross out all discontinued orders and clearly identify any held orders on the MEDREC form. Any additional orders (i.e. lab work), are also to be documented in the appropriate section(s) on the form, as applicable.

According to the licensee's policies, the medication reconciliation process it to be completed within 24 hours of each resident's admission or readmission to the home. When a resident is readmitted to the home, all prior orders are to be documented as discontinued. It is further stated in policy that the medication orders are to be "first" and "second checked" by two different nurses', at which time the available source documents are to be reviewed as applicable. The first and second checks are to be documented in the spaces provided on the bottom of the MEDREC form. The spaces are labeled "Nurse Signature First Check By" and "Nurse Signature Second Check By", respectively.

A) The licensee's medication reconciliation policies were not complied with when resident #026 was admitted to the home on a specified date. In this case, the failure to comply with the medication reconciliation policies lead to a medication error which reached the resident and resulted in a negative outcome.

>Resident #026:

A Critical Incident Report (CIR) was submitted to the Director under the Long-Term Care Homes Act, 2007, on a specified date. The incident report was related to the improper treatment of resident #026, resulting in harm or risk of harm to the resident. According to the CIR, medication reconciliation was incomplete by the RN (RN #107) upon resident #026's admission to the home (on a specified date), resulting in multiple drug omissions. It is indicated in the CIR that resident #026 was transferred to the hospital on a specified date, just over a month after the resident was admitted to the home; and, was admitted to the hospital the following day, at which time the error was discovered. As such, multiple drug omissions occurred between a period of almost five weeks. This incident is further described in WN #2.

Over the course of the inspection, Inspector #655 found that the medication reconciliation process was not completed in accordance with the licensee's policies

when resident #026 was admitted to the home on a specified date. The policies were not complied with in the following ways:

(a) An order which was to be discontinued at the time of admission was identified as such using a check-mark in the box labeled "discontinued" on the MEDREC form; however, it was not clearly crossed out as required by policy for risk management purposes and as indicated in a tip sheet.

(b) Not all medications and other interventions were transcribed from the admission medication list sources onto the MEDREC form as required by the licensee's policies (See WN #2). In addition to the medications that had not been transcribed onto the MEDREC form, the need for another specified intervention was identified on the community pharmacy medication list, but was not found on the MEDREC form.

(c) The accuracy of the information documented on the MEDREC form was not verified by another nurse. On review of the MEDREC form, Inspector #655 found no signatures in the spaces labeled "Nurse Signature First Check By" and "Nurse Signature Second Check By", respectively, located at the bottom of the MEDREC form. On a "Medication Incident Report & Analysis Form" related to the same incident, it is also indicated that the medication reconciliation prepared by RN #107 had not been verified by another nurse. During interviews, both RN #107 and DOC #124 confirmed that the medication reconciliation was not verified by another nurse when resident #026 was admitted to the home as required by the licensee's policies (See WN #2).

(d) The medication list source documents were not identified on the MEDREC form as required by the licensee's policy and as indicated in the medication reconciliation tip sheet.

(e) Resident #026's family – and specifically, their substitute decision maker (SDM), was not involved in the medication reconciliation process. (See WN #4)

Based on the above-described findings, the medication process was not fully completed within 24 hours of resident #026's admission to the home. Moreover, the process was not ever fully completed during the time that resident #026 resided in the home (a period of almost five weeks).

The licensee failed to ensure that the following medication reconciliation policies

were complied with when resident #026 was admitted to the home on a specified date: "Medication Reconciliation" (Policy Number LTC-NAM-F-10.40), effective January, 2015; "Medication Reconciliation – Long Term Care Homes Using Med e-Care" (Policy Number 9.6); and, "Medication Reconciliation- Long Term Care Homes" (Policy Number 2.7.1), revised December, 2016, as well as the identified companion documents.

B) Over the course of the inspection, Inspector #655 found that the licensee's medication reconciliation policies were also not complied with when: resident #037 was admitted to the home on a specified date; when resident #034 was readmitted to the home on a specified date; and, when resident #033 was admitted to the home on a specified date. In each of these three cases, the failure to comply with the medication reconciliation process itself did not have a direct impact on the resident.

>Resident #037:

The licensee's medication reconciliation policies were not complied with when resident #037 was admitted to the home on a specified date.

A medication incident involving resident #037 was reported to Inspector #655 during the inspection by a representative of the pharmacy service provider. The incident involved resident #037 and involved a transcription error which occurred during the medication reconciliation process when resident #037 was admitted to the home on a specified date. At that time, a specified medication was not transcribed onto the MEDREC form. As a result, resident #037 did not receive the previously prescribed medication for a period of approximately 11 weeks. See WN #2 for additional information related to this incident.

Inspector #655 reviewed the MEDREC form dated the date of resident #037's admission, also prepared by RN #107. On review of the form, Inspector #655 found that the licensee's policies related to medication reconciliation had not been complied with in the following ways:

a) The above-noted specified medication had not been transcribed onto the form,
b) The medication list sources were not identified,
c) A medication identified as one to be discontinued was not clearly crossed out, as required by policy for risk management purposes.

>Resident #034:

Over the course of the inspection, Inspector #655 was made aware of another incident related to a transcription error which occurred during the medication reconciliation process upon resident #034's readmission to the home from the hospital. The incident occurred on a specified date; and, was discovered ten days later. The error did not reach resident #034.

As described in WN #3, Inspector #655 reviewed the "Medication Incident Report and Analysis Form" for resident #034 as well as the resident's health care records. Based on the review, it was determined that the medication reconciliation policies were not complied with when resident #034 returned to the home on a specified date in the following ways:

a) Not all medications identified on the readmission medication source lists (hospital discharge summary and hospital prescriptions) were transcribed onto the MEDREC form in order to resolve discrepancies. On the discharge summary printed on a specified date, there was a prescription for a specific medication to be given when needed in a specified dose and frequency. In another hospital prescription document that was printed one day prior, there was no indication that resident #034 had been prescribed the specified medication in the above-noted dose and frequency. The specified medication, in the above-listed dose and frequency was not transcribed onto the MEDREC form completed for resident #034.

b) Not all pre-hospital medications were documented on the MEDREC form or identified as medications to be discontinued. Two of the pre-hospital medications remained on resident #034's MAR when resident #034 returned to the home from the hospital on a specified date for a period of eight days.

c) There was no indication on the MEDREC form as to who prepared the MEDREC form.

d) Medications that were identified as being medications to be discontinued were not clearly crossed out, as required by policy for risk management purposes.

> Resident #033:

Over the course of the inspection, Inspector #655 reviewed the health care

records, including the MEDREC form and the related medication list sources found for resident #033 who was admitted to the home on a specified date.

On review of resident #033's MEDREC form, Inspector #655 found that the medication reconciliation policies had not been complied with in the following ways:

a) Two medications were identified as being medications that were to be discontinued. This was indicated on the form by a check-mark which was placed in the "discontinued" box associated with each of the noted orders. There was no other documentation to indicate that the two medications were to be discontinued. They were not clearly crossed out, as required by policy for risk management purposes.

b) The route of administration was not recorded for two specific medications.

c) The dose was not recorded for two specific medications.

d) The frequency of administration was not documented for two specific medications.

e) The medication list sources were not identified on the MEDREC form.

At the time of the inspection, Inspector #655 was not aware of any medication incidents involving resident #033, related to the above-noted findings. According to the documentation on the MEDREC form, the medication reconciliation form in this case was also completed by RN #107.

The licensee's medication reconciliation policies were not complied with when: resident #037 was admitted to the home on a specified date; when resident #034 was readmitted to the home on a specified date; or when resident #033 was admitted to the home on a specified date.

C) In addition to the above-described findings, Inspector #655 found that issues related to compliance with the licensee's medication reconciliation policies were previously known.

During the inspection, Inspector #655 reviewed a copy of the "Service Delivery Committee" meeting minutes. Attached to the minutes was a document titled "Clinical Consultant Pharmacist Annual Summary for 2017". In this document it is

stated that "medication reconciliation audits score have dropped considerably in the last quarter of 2017". In another attached document titled "Supplementary Medication Management Process Review" for "Quarter 4 (Oct-Nov-Dec) 2017" the above-described decline in medication reconciliation audit scores is depicted in a graph. Next to the visual graph, the following comments were written:

If a discrepancy is noted while completing the medication reconciliation, "it is important to transcribe all orders on the reconciliation form. After clarifying with the physician, the order that should be discontinued would be marked as such. Also, remember that 2 nursing staff should be completing a verification after the physician has authorized reconciliation".

Issues related to compliance with the home's medication reconciliation policy and procedure had been previously identified and shared with the "Service Delivery Committee" before the above-identified instances in which staff failed to comply with the medication reconciliation processes, and before the incident occurred involving resident #026.

2. Other Policies Not Complied With

Over the course of the inspection, Inspector #655 reviewed several other policies related to the medication management system, including:

- "Medication Management System Evaluation" (Policy Number: LTC-NAM-F-10.10), effective January, 2015,
- "Reporting Medication Incidents" (Policy Number 7.3), revised July, 2014,
- "Medication Management – Security & Storage" (Policy Number LTC-NAM-F-10.20), effective January, 2015,
- "Safe Storage of Medications" (Policy Number 4.8), revised July, 2014; and,
- "Sharps Containers and Disposal" (Policy Number: 6.4), revised July, 2014.

As a result of the inspection, it was determined that the above-noted policies were also not complied with. See WN #3 and WN #6 for additional information.

The above-described findings related to policies of the medication management system in the home were widespread. For this reason, the scope of the issue was determined to be a level 3. The severity of this issue was determined to be a level 3 as there was actual harm to a resident related to non-compliance with the licensee's medication policies. As such, a compliance order (CO) will be issued. [s.

8. (1) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

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

Over the course of the inspection, Inspector #655 was made aware of five medication incidents involving a resident (resident #033, #026, #032, #036, and #037, respectively). In each of the five incidents, at least one drug was not administered to the identified resident in accordance with the directions for use specified by the prescriber.

>Resident #033:

The licensee failed to ensure that drugs were administered to resident #033 in accordance with the directions for use specified by the prescriber.

According to the medication incident report related to the above-noted incident, resident #033 requested a specified medication on a specified date, which was to be given on an as needed basis. It is indicated on the medication incident report that resident #033 had two medications contained in similar packaging in their medication supply box; and, at the time of the, incident, the RPN (an agency nurse) who responded to the resident's request for the specified medication, used the other medication in error. According to the medication incident report, within several minutes of the error, resident #033 complained of adverse affects and required further assessment at an external health center.

In a progress note, it is indicated that the agency nurse on duty at the time had reported a medication error to RN #116, as it is described above. In the same progress note, resident #033 is described as having experienced adverse affects. Following the incident, resident #033 was treated for the symptoms that were a result of the error.

During an interview, RPN #121 described the medication incident involving resident #033 as it was reported to them during a shift-report, and as it was described above. Over the course of the inspection, DOC #124 confirmed the same.

The licensee failed to ensure that drugs were administered to resident #033 in accordance with the directions for use specified by the prescriber.

>Resident #026:

The licensee failed to ensure that drugs were administered to resident #026 in accordance with the directions for use specified by the prescriber.

A Critical Incident Report (CIR) was submitted to the Director under the Long-Term Care Homes Act, 2007, on a specified date. According to the CIR, medication reconciliation orders were incomplete by the RN upon resident #026's admission to the home, resulting in multiple drug omissions. It is indicated in the CIR that

resident #026 was transferred to the hospital on a specified date; and admitted to the hospital the following date. It is further indicated that a member of the registered nursing staff was informed by a member resident #026's family two days after the resident had been admitted to the hospital, that resident #026 had suffered from a specific medical complication.

According to the related medication incident report, when resident #026 was admitted to the home, not all of their medications were transcribed, nor communicated to the physician. On the same incident report, six specific medications were identified as having been omitted.

Inspector #655 reviewed the health care record belonging to resident #026. According to the health care record, resident #026 was admitted to the home on a specified date with multiple diagnoses including one diagnosis that posed a risk for the above-noted medical complication, and for which one of the omitted medications would have been prescribed.

On the resident's MEDREC form (dated the date of resident #026's admission to the home), seven medication orders were listed. Of the initial seven medication orders listed, one was identified as an order to be discontinued at the time of the residents' admission. That is, on admission to the home, and as a result of the mediation reconciliation process, a total of six medications were ordered for resident #026.

On review of the admission medication list sources available in resident #026's health care record, eight other medications which were not captured on the above-described MEDREC form were identified by Inspector #655. For one of the eight identified medications, the clinical indication was recorded as being for prevention of the above-noted medical complication on the admission medication list sources.

Inspector #655 reviewed the physician order's and MARs for resident #026 for a period of two months. There was no indication that an order had been written at any time for resident #026 for three specific medications that had not been included on the MEDREC form, including the medication that was previously prescribed for the prevention of the specified medical complication.

On both of resident #026's MARs reviewed by Inspector #655, the specified medication previously prescribed for the prevention of the medical complication was listed under the "alerts" section. However, there was no indication on either

MAR that this medication was otherwise included in the plan of care for resident #026 at any time; and specifically, no indication that resident #026 had received this medication at any time following admission to the home. There was also no indication that resident #026 had received another specified medication which was missed on the MEDREC form at any time following the resident's admission to the home.

In a progress note entered by RPN #128 on the day that the resident was admitted to the hospital, it is indicated that a staff member at the hospital called to inquire about why the specified medication used for the prevention of the specified medical condition had been discontinued for resident #026. According to the note, at that time, RPN #128 informed the caller that resident #026 was allergic to it. In a note entered on the same day by RPN #128, it is further indicated that, according to resident #026's health care record, resident #026 "is on alert (allergic)" to the specified medication.

In a note written by the physician on the same day, in the multidisciplinary progress notes, it is stated that resident #026 was in hospital on that day. In the same note, it is indicated that resident #026 had a specific diagnosis and had been on medication for this diagnosis before; though the medication was not listed on the drug regimen upon admission to the home.

During an interview, RN #107, indicated to Inspector #655 that when resident #026 was admitted to the home, they had completed the admission process for resident #026, including the medication reconciliation process. RN #107 indicated to Inspector #655 that at the time of the admission, resident #026 was known to have multiple diagnoses including a condition which put resident #026 at risk for experiencing the specified medical condition. RN #107 also recalled that they had noted an "alert" in the resident's health care record related to the specified medication that was previously prescribed for resident #026, used to prevent the specified medical condition from occurring. RN #107 indicated to Inspector #655 that they were "confused" by the alert, and did not have a chance to determine its meaning.

During the same interview, RN #107 indicated to Inspector #655 that in transcribing the medications listed on the resident's admission records onto the MEDREC form, they had overlooked some of the medications, explaining that they had copied only the first half of the medications listed on the community pharmacy medication list. According to RN #107, three medications were missed as a result.

During the inspection, Consultant Pharmacist #127 indicated to Inspector #655 that the medication, the specified medication had an "alert" associated with it in resident #026's health care records because it was considered to be a high-alert medication due to the risk of harm associated with the medication, if there is a mistake made with it. Consultant Pharmacist #127 indicated to Inspector #655 that a resident who received an additional dose of the specified medication would be at risk of developing a specific symptom; and, that if a resident's dose was skipped, the resident would be at risk of developing a specific condition or complication.

During the inspection, Inspector #655 spoke with a family member of resident #026. According to the family member of resident #026, resident #026 was known to have a specific medical condition and, for this reason, was receiving a specified medication. The family member of resident #026 indicated to Inspector #655 that the medication in question had been prescribed by the residents' physician over a year ago; and that there was no indication that this medication was to be discontinued. At the time of the interview, the family member of resident #026 indicated to Inspector #655 that following the resident's recent hospitalization, they had learned that resident #026 had not received the prescribed medication at any time since they were admitted to the long-term care home – a period of almost five weeks. The family member of resident #026 further indicated to Inspector #655 that resident #026 had since suffered a specific medical complication; and that they thought it was the consequence of an omission error involving the specified medication.

Over the course of the inspection, DOC #124 indicated that three specific medications were not identified on the MEDREC form and as a result were not administered to resident #026. DOC #124 confirmed that all three medications were previously prescribed for the resident; and, were intended to be included in resident #026's plan of care on admission to the home.

DOC #124, indicated to Inspector #655 that resident #026 did develop the above-described medical complication.

The licensee failed to ensure that drugs were administered to resident #026 over a period of five weeks in accordance with the directions for use specified by the prescriber as a result of an incomplete medication reconciliation process for resident #026 at the time of the resident's admission.

>Resident #032:

The licensee failed to ensure that drugs were administered to resident #032 in accordance with the directions for use specified by the prescriber.

According a medication incident report, RPN #120 found, while conducting a count of controlled substances on a specified date and time that a dose of a controlled substance belonging to resident #032 was still in the medication package. According to the incident report, RPN #120 then administered the dose of the controlled substance to resident #032. In the same incident report, it is indicated that RPN #120 accidentally gave a co-resident's dose of the controlled substance to resident #032.

During an interview, RPN #120 recalled the same medication incident involving resident #032. According to RPN #120, they gave resident #032 a dose of the controlled substance on a specified date and time; but, had accidentally taken that medication from co-resident #035's supply. According to RPN #120, both residents (resident #032 and resident #035) had their own supply of the medication, in the same dosage. RPN #120 further explained to Inspector #655 that approximately two hours later on the same day, they had conducted a count of controlled substances. RPN #120 indicated to Inspector #655 that at the time of the count, they found that a dose of the controlled substance belonging to resident #032 was still in the package assigned to resident #032. RPN #120 indicated to Inspector #655 that at the time, they gave resident #032 the dose from the resident's own supply, unaware at the time that they had already given resident #032 the dose from resident #035's supply. Consequently, according to RPN #120, resident #032 received two separate doses of the controlled substance (double the prescribed dose) during the evening shift of a specified date.

Over the course of the inspection, DOC #124 confirmed that resident #032 had received an extra dose of the controlled substance (or double the prescribed dose) on a specified date. There were no known adverse affects to the resident.

The licensee failed to ensure that drugs were administered to resident #032 in accordance with the directions for use specified by the prescriber when resident #032 received two doses of a controlled substance instead of one during the evening shift of a specified date.

>Resident #036:

The licensee failed to ensure that drugs were administered to resident #036 in accordance with the directions for use specified by the prescriber.

The incident involving resident #036 was initially reported to Inspector #655 by a pharmacy representative. According to the pharmacy representative, a drug had been taken from the emergency box and administered to resident #036 on a specific date; but, it was the wrong drug.

DOC #124 provided Inspector #655 with a copy of the "Medication Incident Report" related to the above-described incident that was reported to the inspector by a pharmacy representative. According to the medication incident report, the following order had been written for resident #036: a specified medication in a specific dosage, to be administered stat (immediately); and then, the same medication (in a specified dose) daily for a specified number of days. In the same incident report, it is stated that in response to the above-noted order, a different medication had been given in error "yesterday and today".

Attached to the medication incident report was a copy of a progress note entered by RPN #125. According to the progress note, RPN #125 was approached by a family member of resident #036 on the day of the incident, at which time the family member expressed concern related to worsening symptoms experienced by resident #036. According to the progress note, the family member of resident #036 reported concern that the above- noted "stat ordered yesterday is not working". In the same note, resident #036 was described as exhibiting specific symptoms. The on-call physician was notified and new orders were received for another specified dose of the specified medication, to be administered immediately; and a different dose of the same medication to be administered in the morning; and then, the same medication to be administered in a different dose once a day for three days. In the progress note it states: "stat order administered" at a specified time, and then four hours later, "noticed that error occurred and writer called on call" again.

Over the course of the inspection, DOC #124 and Director of Resident Services #113 indicated to Inspector #655 that resident #036 received one dose of the wrong medication at the time of the initial, immediate order.

The licensee failed to ensure that drugs were administered to resident #036 in accordance with the directions for use specified by the prescriber.

>Resident #037:

The licensee failed to ensure that drugs were administered to resident #037 in accordance with the directions for use specified by the prescriber.

A medication incident involving resident #037 was initially reported to Inspector #655 by a pharmacy representative. The incident was initially discovered on a specified date; and was subsequently rediscovered just over a month later.

Over the course of the inspection, Assistant Pharmacy Manager #126 indicated to Inspector #655 that Consultant Pharmacist #127 discovered a transcription error during a medication reconciliation audit that was performed on a specified date, for resident #037. According to Assistant Pharmacy Manager #126, the error was discovered on the specified date; but had occurred 11 weeks earlier, when resident #037 was admitted to the home. Assistant Pharmacy Manager #126 indicated to Inspector #655 that when the error was discovered, it was reported to the Director of Resident Services (#113) who investigated the incident. Assistant Pharmacy Manager #126 indicated that as a result of the investigation, the pharmacy was informed that the admission order for a specified medication had not been processed by pharmacy, in error (that the incident was of a pharmacy origin). According to the pharmacy service provider representative, however, the MEDREC form that was prepared and faxed to the pharmacy on the day of the resident's admission to the home did not include an order for the specified medication. At the same time, Assistant Pharmacy Manager #126 indicated to Inspector #655 that the MEDREC form must have been amended after it was faxed to the pharmacy; though pharmacy did not receive a copy of the amended version.

During the inspection, Inspector #655 reviewed an admission medication source list titled "Medication Record", provided to the inspector by Director of Resident Services #113. Among the medications listed was the above specified medication. Inspector #655 reviewed the MEDREC form completed for resident #037, prepared by RN #107 on the day of the resident's admission to the home, and was unable to find any documentation on the form related to the specified medication.

During an interview, Director of Resident Services #113 confirmed that at the time of resident #037's admission to the home, the specified medication was omitted during the medication reconciliation process in error. At the time of the interview, Director of Resident Services #113 indicated to Inspector #655 that resident #037 did not receive the specified medication between a specified period of just over six

weeks, after which time the error was found by Pharmacist Consultant #127.

Inspector #655 reviewed a document titled "MedsCheck LTC – Medication Regimen Review Pharmacist Recommendation Form", completed by Consultant Pharmacist #127 on a specified date, just over six weeks after resident #037's admission to the home. On the form, it was indicated that a prescription for a specified medication (found on an admission medication list source) was not transcribed onto the MEDREC form when the resident was admitted to the home . On the same document, clarification was requested as to whether this was intentional or an error. On the document it is indicated that the potential error was reviewed with an RPN; and, a hand written note on the bottom of the form indicated that the specified medication was to be restarted.

Inspector #655 reviewed the physician's orders in resident #037's health care record and found only one order related to the specified medication. The order was dated just over a month later than the date at which the error was initially discovered. In addition, in a note written by the physician around the same time in the multidisciplinary progress notes, it was also indicated that the specified medication was to be restarted at that time as the resident was known to have a specific medical condition.

Inspector #655 reviewed the Medication Administration Records (MARs) belonging to resident #037 for a period of four months. The specified medication was not listed on any of the MARs prior to a specified date over 11 weeks after the resident's admission (and five weeks after the error was initially discovered). That is, there was no indication that resident #037 had been given the specified medication at any time over a period of over 11 weeks. On review of the resident's health care record, Inspector #655 noted that resident #037 was known to have a specific medical condition associated with the use of the specified medication which had been omitted.

Over the course of the inspection, DOC #124 indicated to Inspector #655 that all medications that are identified on the medication list sources at the time of a resident's admission to the home are medications which had been prescribed by a physician and are expected to be transcribed onto the MEDREC so that the need to continue or discontinue the given medication may be assessed by the attending physician in the home.

The licensee failed to ensure that a drug was administered to resident #037 in

accordance with the directions for use specified by the prescriber over a period of over 11 weeks, as the result of a medication reconciliation process error at the time of the resident's admission.

The severity of this issue was determined to be a level 3 as there was actual harm to a resident as a result of a medication incident. The scope of the issue was a level 3 (widespread) as at least one medication was not administered in accordance with a prescribers directions in five out of six incidents that were reviewed during the inspection. The home had a level 4 compliance history, where continued non-compliance was identified with the original area of non-compliance:

- a written notification (WN) and Voluntary Plan of Correction (VPC) was issued under O. Reg. 79/10, s. 131 (2) on May 23, 2017 (Resident Quality Inspection #2017_617148_0015),
- a written notification (WN) and Voluntary Plan of Correction (VPC) was issued under O. Reg. 79/10, s. 131 (2) on Mar 23, 2017 (Complaint Inspection #2017_619550_0009); and,
- a written notification (WN) and Voluntary Plan of Correction (VPC) was issued under O. Reg. 79/10, s. 131 (2) on Mar 27, 2017 (Complaint Inspection # 2017_619550_0010).

As such, a compliance order will be issued. [s. 131. (2)]

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

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

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).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to 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.

Over the course of the inspection, Inspector #655 reviewed the medication incident reports related to five separate medication incidents that involved a resident. On two of the five medication incident reports that were reviewed, there was no record of the immediate actions taken to assess and maintain the resident's health: one incident involved resident #032, and the other involved resident #037.

>Resident #032:

The incident involving resident #032 occurred on a specified date. At the time of the incident, resident #032 was given two doses of a controlled substance instead of one during an evening shift, as described in WN #2.

On the medication incident report, there was no information found related to the immediate actions that were taken to assess and maintain resident #032's health when the incident was discovered on the same shift.

During the inspection, DOC #124 indicated to Inspector #655 that the immediate actions take to assess and maintain resident #032's health at the time of the incident were documented in the resident's progress notes.

At the same time, DOC #124 indicated to Inspector #655 that normally, the applicable resident's progress notes would be printed out and attached to the corresponding medication incident report to ensure that the records are kept together. There were no progress notes attached to the incident report completed for resident #032 regarding the incident that occurred on a specified date.

>Resident #037:

The incident involving resident #037 was related to an error that initially occurred on a specified date (when the resident was admitted to the home), and resulted in a medication omission, as described in WN #2.

As described in WN #2, it was initially discovered on a specified date just over six weeks after the resident's admission to the home that a specific medication had not

been transcribed onto resident #037's MEDREC form at the time of the residents of admission to the home.

There was no indication that at that time, the incident had been documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

According to Assistant Pharmacy Manager #126, Pharmacist Consultant #127 identified the same error during a medication reconciliation audit that took place over a month later - the specified mediation, still at that time had not been restarted. On the medication incident report that was dated the day after the incident was rediscovered a month later, there was no information found related to the immediate actions taken to assess and maintain resident #037's health when the incident was discovered; and no progress notes were attached to the incident report.

The licensee failed to ensure that the immediate actions taken to assess and maintain resident #032 and resident #037's health were recorded, together with the documented medication incident.

2. The licensee has failed to ensure that every medication incident involving a resident is (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.

i. Inspector #655 reviewed the document titled "Medication Incident Report" related to a medication incident that occurred on a specified date involving resident #032. The incident, in which resident #032 was given two doses of a controlled substance during the evening shift instead of one, as described in WN #2, occurred on a specified date.

On the medication incident report, there is a section ("Reported to:") in which the individual completing the report can identify which individuals were notified of the incident. The options include:
- Resident/POA,
- Pharmacy service provider,
- Attending physician,
- Director of care,

- Prescriber,
- Medical Director; and,
- RN (EC).

On review of the above-identified medication incident report, the signature of DOC #124 was found, and a check mark was entered in a box next to the option "RN (EC)". There was no indication that that the resident or the resident's substitute decision maker, the pharmacy service provider, the attending physician, the prescriber, or the medical director had been notified of the incident.

During an interview, RPN #120 confirmed that at the time of the above-noted incident, they had notified the charge nurse (as opposed to an RN in the extended class (EC)). RPN #120 indicated to Inspector #655 that they had not, however, notified the resident's family because the incident was discovered at night. RPN #120 indicated to Inspector #655 that they had asked the incoming night nurse to ask the day nurse to notify the family of their behalf. RPN #120 indicated to Inspector #655 that resident #032's attending physician (who was also the Medical Director) should have been aware of the incident because they had written a note in the "doctor's book" indicating that the incident had occurred.

During an interview, DOC #124 indicated to Inspector #655 that when a resident's substitute decision-maker is informed of a medication incident involving the resident, it will be documented in the resident's progress notes. At the same time, DOC #124 indicated to Inspector #655 that it will also be documented in the progress notes if the physician has been notified.

Inspector #655 reviewed the health care record belonging to resident #032, including progress notes. In a progress note entered on the day of the incident by RPN #120, it is indicated that the charge nurse was notified of the incident. There was no indication in the progress notes as to whether any other individuals, such as the resident or the resident's substitute decision-maker, the physician, or the pharmacy service provider had been notified of the incident.

Over the course of the inspection, Inspector #655 also reviewed a medication incident report related to a medication incident involving resident #036.

>Resident #036:

On the "Medication Incident Report" involving resident #036 (in which the resident

was given the incorrect medication on a specified date, as described in WN# 2), it was indicated that the Director of Care and the on-call physician were notified of the incident. On the medication incident report, there was, however, no indication as to whether the attending physician, prescriber, Medical Director, or RN (EC) had been notified of the incident. Over the course of the inspection it was determined that that the pharmacy service provider and the resident's POA had been notified; although there was also no indication of this on the medication incident report.

ii. Over the course of the inspection, it was determined that the pharmacy service provider was not notified of every medication incident involving a resident:

During an interview, Consultant Pharmacist #127 indicated to Inspector #655 that the home is encouraged to inform the pharmacy service provider of all medication incidents that occur in the home. At the same time, Consultant Pharmacist #127 indicated to Inspector #655 that they were informed of every medication incident that was of a pharmacy related origin; but that they were not certain that they were informed of all medication incidents that were of a nursing related origin.

During another interview, the same Consultant Pharmacist notified Inspector #655 that there had been no pharmacy related medication incidents reported to the pharmacy service provider in 2018; and that one nursing related incident had been reported to the pharmacy in 2018. According to Pharmacy Consultant #124, the medication incident that was of a nursing related origin that was reported to the pharmacy service provider occurred in a specified month. There were no medication incidents reported to the pharmacy service provider any other time in 2018, according to the Consultant Pharmacist.

Over the course of the inspection, DOC #124 indicated to Inspector #655 that if a medication incident is of a pharmacy related origin (such as a transcription error from pharmacy), or, if the medication incident is "complex", it will be reported to pharmacy. There was no indication that all medication incidents occurring in the home that involve a resident would be reported to the pharmacy service provider.

During an interview, Assistant Pharmacy Manager #126 described that they were responsible for reviewing medication incident reports and compiling data about those medication incidents on a monthly, and then quarterly basis. At the same time, Assistant Pharmacy Manager #126 indicated to Inspector #655 that the pharmacy service provider had not received medication incident reports for any of the following medication incidents involving a resident:

- The medication incident which occurred on a specified date, involving resident #033 (in which resident #033 was given the wrong medication in error),
- The medication incident which occurred on a specified date, involving resident #032 (in which resident #032 was given two doses of a controlled substance instead of one); nor,
- The medication incident which was discovered on a specified date, involving resident #026 (in which a medication reconciliation error that occurred at the time of the resident's admission to the home resulted in multiple drug omissions).

According to Assistant Pharmacy Manager #126, the only medication incident received by pharmacy was related to a medication incident that occurred the month prior, and involved resident #036 – the same incident that was referred to by Consultant Pharmacist #127 during the above described interview. Assistant Pharmacy Manager #126 indicated to Inspector #655 that while there had been no medication incident report received by the pharmacy service provider related to the above-identified medication incident related to resident #026, they had otherwise been informed that the incident had occurred. Assistant Pharmacy Manager #126 had not, however, been aware or otherwise informed of the incident involving resident #033 or of the incident involving resident #032.

According to the policy titled "Reporting Medication Incidents" (Policy Number 7.3), revised July, 2014, all mediation incidents, regardless of the origin, are to be communicated to the pharmacy service provider by providing a completed medication incident form. In the policy it is indicated that for incidents of a nurse or physician origin, the home is to investigate the circumstances of the incident. After the investigation is complete and the details of the incident have been documented, the Medication Incident Report is to be communicated to Classic Care Pharmacy.

On each of the medication incident reports (those completed for resident #033, #032, and #026), all the following sections were found to be completed:
- "Written description of the incident",
- "Analysis of incident", and,
- "Correction action plan".

On each of the above-noted medication incident reports there is a space provided for the signature of the Director of Care; and, a space provided for the signature of the "Pharmacy Rep". On each of the medication incident reports, the signature of the Director of Care was found. None of the medication incident reports, however,

included the signature of a "Pharmacy Rep".

During an interview, Director of Resident Services #113 indicated to Inspector #655 that all medication incident reports are expected to be sent to the pharmacy service provider.

The licensee failed to ensure that every medication incident involving a resident was reported to the pharmacy service provider. [s. 135. (1)]

2. The licensee has failed to ensure that all medication incidents are documented, reviewed and analyzed.

Over the course of the inspection, Inspector #655 was made aware of two other medication incidents (in addition to the incident involving resident #026) related to a transcription error. The first was related to resident #034, and did not reach the resident. The second involved resident #037, and it did reach the resident. There was no indication that either incident had been reviewed or analyzed when they were discovered.

>Resident #034:

Inspector #655 was provided with a "Medication Incident Report and Analysis Form" related to the first incident. According to the medication incident report, the incident occurred on a specified date. In the section "written description of incident", it was indicated that medication reconciliation was completed for resident #034 on a specified date, upon the resident's return to the home from the hospital. It is further stated that this was faxed to pharmacy; and that not all of the previous orders were removed from the resident's MAR.

On the same form, it is indicated that the incident was discovered by a nurse, and that the medications involved included medications of an oral (tablet/capsule) form, as well as medication in an injectable form. According to the medication incident report, the error did not reach the resident and therefore caused no harm. On the medication incident report, the error was classified as a "processing error". No causes or contributing factors were identified on the form (from a list of multiple options). In addition, there was no documentation found on the form under the section titled "Analysis of Incident"; or under the section titled "Corrective Action Plan". Under a statement which reads "Med incident has been documented, reviewed and analyzed by the multidisciplinary care team. Corrective action to

prevent future incidents and harm to resident have been reviewed and documented", there is a space for the signatures of the Director of Care, the Medical Director or Physician, and the "Pharmacy Rep". There were no signatures found on the incident report.

During the inspection, Assistant Pharmacy Manager #126 indicated to Inspector #655 that the above-noted medication incident report had not been submitted to the pharmacy service provider for review. At the same time, Assistant Pharmacy Manager #126 indicated that the pharmacy was, however, notified via email that there was an incident. According to the Assistant Pharmacy Manager #126, the pharmacy was notified that an error occurred and that it occurred on a specified date, when the resident returned from hospital. Assistant Pharmacy Manager #126 indicated, however, that the pharmacy had no record of the resident being to hospital at that time; and that when they looked in the electronic census record, there was also no indication that the resident had been hospitalized at that time.

During an interview, Director of Resident Services #113 indicated to Inspector #655 that they were aware of an incident in which resident #034 was readmitted to the home from hospital with two different sets of hospital discharge orders. According to Director of Resident Services #113, the most recent set of orders from the hospital was used to complete the medication reconciliation process. At the same time, Director of Resident Services #113 indicated to Inspector #655 that the incident did not occur on the date specified on the medication incident report, and had likely occurred the following month. At the time of the interview, Director of Resident Services #113 was unable to elaborate, confirm the date of the incident or confirm whether the incident had reached the resident or not. Director of Resident Services #113 indicated that they would have to speak with DOC #124. According to Director of Resident Services #113, DOC #124 is the designate who would complete any follow-up related to medication incidents that occur on resident #034's resident home area; and regardless, all medication incidents reports are given to DOC #124 when complete.

During the inspection, DOC #124 indicated to Inspector #655 that they had not looked into the above-described incident, noting that there would be additional notes written on the medication incident report if they had. DOC #124 indicated that the pharmacy "must have" been notified; possibly verbally, about this incident.

During an interview, DOC #124 clarified that the above-described incident occurred on a specified date, not the date that was indicated on the medication

incident report; and, that the incident was discovered ten days later. On the same day, DOC #124 explained to Inspector #655 that on the date the incident occurred, resident #034 returned to the home from hospital, at which time the medication reconciliation process was accurately completed and faxed to the pharmacy. DOC #124 further explained, however, that additional hospital discharge documents were sent to the home the following day. DOC #124 indicated that initially it was suspected that the medication reconciliation process may have been based on the incorrect hospital prescriptions; however, according to DOC #124 it was ultimately determined that there had been no transcription error, and that the resident had not been affected. According to DOC #124 the physician or nurse practitioner contacted the hospital at that time and confirmed that the first hospital discharge prescriptions (received when the resident returned to the home on a specified date) were correct. At the time of the interview, DOC #124 indicated that for this reason, the incident was not pursued further.

Inspector #655 reviewed the health care record belonging to resident #034 and found that the medication reconciliation process was not completed in accordance with the licensee's policies, as described in WN # 1. Among the issues identified, it was found that not all pre-hospital medications were discontinued, and as a result two specific medications, which were also not listed on the MEDREC form, remained on the resident's MAR for a period of eight days following the resident's readmission to the home.

During the inspection, Inspector #655 reviewed the resident's MAR and the MEDREC form with DOC #124 who confirmed the same. DOC #124 was not aware of the transcription issues until Inspector #655 reviewed the MAR with them. DOC#124 indicated to Inspector #655 that they had not previously reviewed resident #034's MAR, though on the medication incident report related to this incident, it is stated that "not all previous orders were removed from the MAR".

There was no indication that the medication incident related to a transcription error during the medication reconciliation process when resident #034 was readmitted to the home from hospital on a specified date, had been reviewed or analyzed by DOC #124 or a designate, or by the pharmacy service provider.

>Resident #037:

The second incident involved resident #037, related to an error that initially occurred on a specified date, when the resident was admitted to the home. The

incident was initially discovered on a specified date - approximately one month before the issue was corrected. Therefore, it resulted in a medication omission for a period of 11 weeks, as described in WN #2.

As described in WN #2, a document titled "MedsCheck LTC – Medication Regimen Review Pharmacist Recommendation Form", was reviewed by Inspector #655. The form was dated just over six weeks after the resident's admission to the home. On the form it was indicated that a prescription for a specified medication (found on an admission medication list source) was not transcribed onto the MEDREC form when the resident was admitted to the home. On the same document, clarification was requested as to whether this was intentional or an error. On the document it is indicated that the potential error was reviewed with an RPN; and, a hand written note on the bottom of the form indicated that the specified medication was to be restarted.

There was no indication that, at that time (when the error was initially discovered), a medication incident report had been completed. In addition, there was no record to indicate that the incident had been reviewed or analyzed any further by the DOC or designate. In resident #037's MAR, there was also no indication that the medication had actually been restarted when the incident was first discovered.

According to Assistant Pharmacy Manager #126, Pharmacist Consultant #127 identified the same error during a medication reconciliation audit that took place just over a month after it was initially discovered. As described in WN #2, Assistant Pharmacy Manager #126 indicated to Inspector #655 that Director of Services #113 was made aware of the discovery and had informed the pharmacy that the error was a processing error of a pharmacy origin. At the same time, Assistant Pharmacy Manager #126 indicated to Inspector #655, however, that the original MEDREC form that was provided to the pharmacy when the resident was admitted to the home, did not include the specified medication. According to Assistant Pharmacy Manager #126, the incident was a transcription error of nursing origin. Assistant Pharmacy Manager #126 indicated to Inspector #655 that it is not within their role to analyze incidents of a nursing origin.

During an interview, Director of Resident Services #113 was aware that an incident had occurred involving resident #037, but could not recall any details. At that time, Director of Resident Services #113 indicated to Inspector #655 that they had not received or completed a medication incident report related to the incident themselves; and would have to look into it further in order to determine what had

occurred.

On the same day, Inspector #655 was provided with a medication incident report that was dated one day after the error was discovered for a second time. The medication incident report had been completed by Assistant Pharmacy Manager #126. There was no indication that the incident had been reviewed or analyzed by the DOC or designate prior to the inspection.

Over the course of the inspection, it was confirmed that the incident was a transcription error of a nursing origin which resulted in the omission of a specified medication for a period of over 11 weeks (see WN #2). Prior to the inspection, neither DOC #124 nor Director of Resident Services #113 had been aware that the omission of the specified medication for resident #037 had continued after it was first discovered.

The licensee failed to ensure that all medication incidents were documented, reviewed, and analyzed.

The severity of the issues identified under O. Reg. 79/10, s. 135, was determined to be a level 2 as there was potential for actual harm to residents as a results of the above-described findings. The scope of the issue was a level 3, as the above-described findings under s. 135 were related to all six of the medication incidents that were reviewed during the inspection. The home had a level 3 compliance history, with one or more related non-compliance in the last three years: a written notification (WN) was issued under O. Reg. 79/10, s. 135 (1) on May 23, 2018, (Resident Quality Inspection #2017_617148_0015). As such, a compliance order (CO) will be issued. [s. 135. (2)]

3. The licensee has failed to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

In accordance with sections 115 (1) and (3) (b) of Ontario Regulation 79/10, the quarterly evaluation of the medication management system must include a review of the reports of any medication incidents and adverse drug reactions referred to in sections 135 (2) and (3) by an interdisciplinary team.

In the licensee's policy titled "Medication Management System Evaluation" (Policy

Number: LTC-NAM-F-10.10), effective January, 2015, the same requirements are outlined.

Initially, during the inspection, DOC #124 was unable to speak to any processes in place for the quarterly review of all medication incidents. At the same time, DOC #124 indicated to Inspector #655 that each medication incident is reviewed at the time the incident is reported; and then, DOC #124 indicated that they will go over all medication incidents once every six months, approximately. DOC #124 indicated to Inspector #655 that there had been no medication incidents in the home in 2018 until a specified month. At the same time, DOC #124 was unable to confirm when the last review of all medication incidents would have taken place.

Later, DOC #124 indicated to Inspector #655 that the "Resident Services Department/Nursing Department Team" (the nursing department team) discusses and reviews medication incidents, if any have occurred in the home, when they meet. According to DOC #124 the nursing department team met on March 14, 2018; with the previous most recent meeting being held in December, 2017.

Over the course of the inspection, Director of Resident Services #113 provided Inspector #655 with a copy of the nursing department team minutes for the months of January, 2017, and October, 2017. Director of Resident Services #113 indicated to Inspector #655 that they had provided minutes for these months because these were the meetings at which medication issues were discussed.

The meeting minutes dated October 25, 2017, were reviewed by Inspector #655. There was no indication that any members of the interdisciplinary team were present at this meeting. In the meeting minutes there is a record of a discussion that took place related to the "narcotic destruction box", and regarding the "pre-pouring" and crushing of medications. However, there was no reference to any specific medication incidents that had occurred in the home or medication incident reports.

During an interview, Director of Resident Services #113 confirmed that only registered nursing staff attend the nursing department team meetings. At the same time, Director of Resident Services #113 confirmed that at the nursing department meetings, the staff are made aware that there was an incident, and they are reminded about certain practices. Director of Resident Services #113 indicated to Inspector #655 that there is no review of the medication incident reports at these meetings.

During an interview, Consultant Pharmacist #127 indicated to Inspector #655 that they attend the Service Delivery Committee meetings at the home; but did not speak to a process in place for the review of medication incidents. At the same time, Consultant Pharmacist #127 indicated to Inspector #655 that they could not confirm that they had been notified of medication incidents which were of a nursing origin.

During an interview, Assistant Pharmacy Manager #126 indicated to Inspector #655 that quarterly evaluations of the medication management system are completed by Consultant Pharmacist #127; and presented at Professional Advisory Committee meetings (or, Service Delivery Committee meetings in this home). Assistant Pharmacy Manager #126 indicated to Inspector #655 that their own role was to review medication incident reports and enter data into excel. Assistant Pharmacy Manager #126 indicated that monthly and quarterly reports are subsequently created. According to Assistant Pharmacy Manager #126, the reports are to include medication incidents of both pharmacy and nursing origins. At the same time, Assistant Pharmacy Manager #126 indicated that not all medication reports are submitted to the pharmacy; and that only data related to incidents that are reported to the pharmacy are captured in the reports. Over the course of the inspection, DOC #124 also indicated to Inspector #655 that not all medication incidents are reported to the pharmacy service provider.

Inspector #655 was provided with a copy of the Service Delivery Committee meeting minutes dated September 26, 2017. Under a section titled "Medication incidents" it is indicated that there was one pharmacy incident in the second quarter of 2017, and 12 non-pharmacy incidents (omissions all occurring on the same day, during the same medication pass by one staff member) in the second quarter of 2017. There was no other documentation in the meeting minutes related to the review of reports of medication incidents in order to reduce and prevent medication incidents and adverse drug reactions.

During an interview, Director of Resident Services #113 indicated to Inspector #655 that when there are medication errors, the incident will be reviewed at either the Service Delivery Committee meeting, or the Nursing Executive Committee meeting. According to Director of Resident Services #113, the Service Delivery Committee is interdisciplinary and includes among the members, a pharmacy representative and physician; whereas the Nursing Executive Committee meeting involves only the nursing managers. According to Director of Resident Services

#113, the Service Delivery Committee meets on a quarterly basis. Director of Resident Services #113 indicated to Inspector #655 that they normally attend the Service Delivery Committee meetings, as well as DOC #124. At the same time, Director of Resident Services #113 indicated to Inspector #655 that they did not believe medication incidents were regularly reviewed at the Service Delivery Committee meetings, unless it was a major incident (such as the incident that occurred involving resident #026, as described in previous findings). Director of Resident Services #113 indicated to Inspector #655 that they may discuss the incidence of medication incidents without reviewing the details of the incident. Director of Resident Services #113 indicated to Inspector #655 that when information related to medication incidents is provided, it is provided by Consultant Pharmacist #127.

As a result of the inspection, Inspector #655 found that the incidence of medication incidents occurring in the home is discussed on a quarterly basis at Service Delivery Committee Meetings. However, there is no process in place whereby the reports of medication incidents are reviewed quarterly. In addition, the information reviewed at Service Delivery Committee meetings is based on the information that is provided to the pharmacy service provider using medication incident reports. As not all medication incidents are reported to the pharmacy service provider, not all medication incidents are considered in the quarterly review process.

There was no indication that a process was in place to ensure that the reports of all medication incidents were reviewed by an interdisciplinary team on a quarterly basis in order to reduce and prevent medication incidents and adverse drug reactions.

The licensee failed to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

The severity of the issues identified under O. Reg. 79/10, s. 135, was determined to be a level 2 as there was potential for actual harm to residents as a results of the above-described findings. The scope of the issue was a level 3, as the above-described findings under s. 135 were related to all six of the medication incidents that were reviewed during the inspection. The home had a level 3 compliance history, with one or more related non-compliance in the last three years: a written notification (WN) was issued under O. Reg. 79/10, s. 135 (1) on May 23, 2018,

(Resident Quality Inspection #2017_617148_0015). As such, a compliance order (CO) will be issued. [s. 135. (3)]

Additional Required Actions:

CO # - 003, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 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. 2007, c. 8, s. 6 (5).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #026 or resident #026's substitute decision-maker (SDM) were given an opportunity to participate fully in the development and implementation of resident #026's plan of care.

During the inspection, Inspector #655 spoke with a member of resident #026's

family (resident #026's SDM).

Resident #026's SDM indicated to Inspector #655 that resident #026 had been taking a specific type of medication prior to their admission to the long-term care home; and, that the resident was expected to continue taking the medication following their admission. Resident #026's SDM indicated, however, that it was later determined that the resident had in fact not received the medication at any time since their admission to the home.

According to resident #026's SDM, when resident #026's family visited the home following the resident's admission to the home and prior to the resident's hospitalization, staff were observed to be administering medications to resident #026 in a specified way. Resident #026's SDM indicated that they had assumed that resident #026 was receiving all of the required medications this way. At the same time, resident #026's SDM indicated to Inspector #655 that the medications that were included in resident #026's plan of care following the medication reconciliation process had never been reviewed with them. Resident #026's SDM further indicated to Inspector #655 that if the medications had been reviewed with them and/or other family members, the omission would have been identified immediately. Resident #026's SDM further indicated that they would have also expected to be notified if any pre-admission medications had been discontinued.

Over the course of the inspection, DOC #124 provided Inspector #655 with the companion document titled "How to Conduct a Best Possible Medication History" (BPMH). The first item listed in conducting a BPMH in the companion document is to "interview the Resident and/or family member".

During an interview, RN #107 indicated to Inspector #655 that they had prepared the MEDREC form for resident #026 the day that the resident was admitted to the home. RN #107 described looking at admission records and medication list sources in this case, and recalled that they had asked one of the resident's family members specifically about whether the resident was taking a medication for a specific health condition. There was no indication that RN #107 had asked about any other medications, such as the medication that was identified by the resident's family member above as having been omitted. In addition, according to RN #107, the family member that was asked was not the above-identified SDM.

According to RN #107, a care conference was also held for resident #026, at which time the resident's family asked about whether the resident was taking their

medications. RN #107 indicated to Inspector #655 that the family members who attended the care conference did not ask about specific medications at the time, therefore there was no review of specific medications. RN #107 was otherwise unable to speak to the involvement of resident #026's SDM in the medication reconciliation process, or in the development of the resident's plan of care with regards to medications at the time of the resident's admission to the home.

During an interview, Director of Resident Services #113 indicated to Inspector #655 that a resident's family is "not necessarily" expected to be involved in the medication reconciliation process. At the same time, Director of Resident Services #113 indicated that a resident's family may provide the medications or a list of medications; and may be consulted if clarification is required or if any changes were being made to the resident's medication regimen. According to Director of Resident Services #113, medications would otherwise be reviewed at a care conference.

The licensee has failed to ensure that resident #026's substitute decision-maker was given an opportunity to participate fully in the development and implementation of resident #026's plan of care with regards to the resident's medication regimen. [s. 6. (5)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to resident #026 as specified in the plan.

Inspector #655 reviewed the health care record belonging to resident #026.

In a progress note entered on a specified date by RD #142, it is indicated that resident #026 had experienced significant weight loss within a one month period following admission to the home. In the progress note it is written that resident #026 was supposed to be receiving a nutritional supplement when needed. Indicators for when the resident needed the nutritional supplement were outlined in the same note. In the same note it is indicated that RD #142 had checked the electronic Medication Administration Record (MAR) belonging to resident #026 and found that the order for a specified nutritional supplement was not transcribed onto the MAR. According to the progress note, RD # 142 asked the nurse to re-fax the order on the same day.

Inspector #655 reviewed the orders written for resident #026 in the resident's health care record. In an order written by RD # 142 on a specified date, it is

indicated that resident #026 was to receive the nutritional supplement at meal times when needed. The order included specific indications for when the resident needed the supplement. In the same order, it is indicated that resident #026 was also to receive another nutritional supplement several times a day. The order was dated ten days prior to the above-described progress note. Next to the order was a hand written note which indicated that the order was not in the e-MAR. The remaining note reads "please enter it into e-MAR".

Inspector #655 reviewed the flow sheets and MAR for resident #026. According to the flow sheets, resident #026 exhibited the indicators for requiring the nutritional supplement more than once on three separate dates.

According to resident #026's MAR, resident #026 was first given one of the above-described nutritional supplements ten days after the order was initially written; the same day that the RD wrote the progress note described above. There was no indication on resident #026's MAR that they had received the other nutritional supplement at any time in a specified month.

During the inspection, RD #142 indicated to Inspector #655 that an order for a nutritional supplement had initially been written on a specified date. However, RD #142 indicated to Inspector #655 that ten days later, they had discovered that the order for the nutritional supplement was not identified on the resident's MAR. RD #142 further indicated to Inspector #655 that at that time, they were told by staff that the resident had still been receiving it. There was no record found by Inspector #655 that demonstrated this.

Over the course of the inspection, DOC #124 indicated to Inspector #655 that when a resident has been given a nutritional supplement, it is documented on the resident's MAR.

The licensee failed to ensure that the care set out in resident #026's plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to resident #019 as specified in the plan.

During the inspection, resident #019 indicated to Inspector #655 that a staff member who works during a specific shift, PSW #135, had been rough with them during care. DOC #124 was made aware.

Later in the inspection, resident #019 indicated to Inspector #655 that normally, two staff members assist them with their personal care needs.

Inspector #655 reviewed the health care record belonging to resident #019.

According to resident #019's plan of care, and as indicated in resident #019's care plan and kardex, resident #019 requires a minimum of four staff members for physical assistance with care needs.

During an interview, PSW #135 indicated to Inspector #655 that they normally work the specific shift that was identified by the resident, and are assigned to provide resident #019's care on a rotational basis. PSW #135 indicated to Inspector #655 that when they are not assigned as the primary caregiver for resident #019, they will assist other staff to provide care to resident #019 given the resident's care needs. At the same time, PSW #135 indicated to Inspector #655 that when resident #019 requires assistance with care needs the task is normally done by two staff members (as opposed to four).

During the inspection, DOC #124 indicated to Inspector #655 that they had investigated the concern that was reported to Inspector #655 by resident #019. DOC #124 indicated that as a result of the investigation they had concluded that resident #019's plan of care was not being followed with regards to the level of assistance required for the provision of care.

During the inspection, Director of Resident Services #113 indicated the same. According to Director of Resident Services #113, resident #019 should not have received the assistance of two persons. Director of Resident Services #113 indicated to Inspector #655 that until such time that the plan of care is revised, it is expected that resident #019 is assisted by three to four staff persons.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #019 as specified in the plan. [s. 6. (7)]

4. The licensee failed to ensure that staff who provide direct care to a resident have convenient and immediate access to the resident's plan of care.

Inspector #655 reviewed the health care record belonging to resident #003. According to a Minimum Data Set (MDS) assessment, resident #003's plan of care

included a specific intervention for continence.

During the inspection, resident #003 indicated to Inspector #655 that they no longer used the specified intervention. According to resident #003, the intervention had been removed approximately three months ago, or possibly longer.

Inspector #655 reviewed resident #003's current care plan. In the care plan document, it is indicated that resident #003 uses the above-noted intervention for continence.

During the inspection, RN #116 indicated to Inspector #655 that resident #003 no longer used the specified intervention. At the same time, RN #116 indicated to Inspector #655 that information related to resident #003's plan of care – specifically, with regards to continence care, is kept in the resident's care plan and kardex. RN #116 indicated to Inspector #655 that staff normally access an updated kardex and/or care plan in hard-copy, in a binder. According to RN #116, the nurse updates a resident's plan of care during report, at which time changes are made to the hard-copy kardex and care plan, with information that has changed being crossed out. At the time, neither RN #116 nor PSW #136 or PSW # 141 were able to locate an updated, hard-copy, care plan or kardex for resident #003.

Later that same day, RN #116 indicated to Inspector #655 that staff are actually now required to refer to the resident's electronic kardex, which had not been updated for resident #003. The above-listed staff members were previously unaware of this change in accessing the resident's care plan.

Inspector #655 also reviewed the health care record belonging to resident #025. In a Minimum Data Set (MDS) assessment, resident #025 was identified as being frequently incontinent of urine.

According to resident #025's care plan, resident #025 is unable to toilet independently due to impaired mobility, resulting in urinary incontinence. It is further indicated in the care plan that resident #025 requires physical assistance for toileting. The care plan also included specific directions related to the use of a specified incontinent product.

During an interview, PSW #139 indicated to Inspector #655 that resident #025 is not normally incontinent during the day. PSW #139 indicated to Inspector #655 that resident #025 normally toilets independently during the day but will request

assistance if needed. PSW #139 denied the need to implement the above-noted directions related to the residents incontinent product at any time during the day.

During the inspection, PSW #139 indicated to Inspector #655 that information related to the resident's plan of care is kept in the resident's care plan located in the resident's hard-copy health care record. PSW #139 indicated that staff also have access to an electronic copy; however, PSW #139 declined to demonstrate access to the electronic version, stating that they were more comfortable accessing the paper copy. At the same time, PSW #139 reviewed resident #025's hard-copy health care record in the presence of the inspector in order to locate the hard-copy care plan. PSW #139 showed Inspector #655 a document titled "Personal Care Authorization Form" (a consent form), and indicated that this was the document that they would refer to for information about the resident's plan of care. At that time, PSW #139 acknowledged that there was no information contained on this document related to continence care needs. PSW #139 was unable to demonstrate that they could locate information related to resident #025's plan of care; specifically, related to continence care.

During an interview, PSW #140 indicated that some information related to a resident's plan of care is kept in a binder and some information is accessible on the computer. At the same time, PSW #140 denied that staff are expected to refer to the kardex for information about a resident's plan of care. PSW #140 demonstrated to Inspector #655 where they would go instead to access the information that is available electronically: the PSW flow sheets, which are accessed via "point of care". Inspector #655 observed that the flow sheets contained minimal information related to the resident's individualized plan of care.

Over the course of the inspection, the following five staff members were unable to demonstrate that they had immediate and convenient access to a resident's current plan of care: PSW #136, PSW #139, PSW #140, PSW #141, and RN #116.

The licensee failed to ensure that staff who provide direct care to a resident have convenient and immediate access to the resident's current plan of care. [s. 6. (8)]

5. The licensee failed to ensure that a resident's plan of care was revised when the resident's care needs changed or the care set out in the plan was no longer necessary.

i) The licensee failed to ensure that resident #003's plan of care was revised when

the resident's care needs changed or the care set out in the plan was no longer necessary.

Inspector #655 reviewed the health care record belonging to resident #003. According to a Minimum Data Set (MDS) assessment, resident #003 required the use of a specified intervention to promote continence.

During an interview, resident #003 indicated to Inspector #655 that they no longer used the specified intervention. According to resident #003, the intervention had been removed approximately three months ago, or possibly longer.

Inspector #655 reviewed resident #003's current care plan. In the care plan document, it is indicated that resident #003 uses the specified intervention for continence.

During an interview, PSW #136 indicated to Inspector #655 that staff assist resident #003 with toileting upon request from the resident. PSW #136 further indicated that resident #003 had not used the above-noted specified intervention in some time.

During an interview, RN #116 indicated to Inspector #655 that resident #003 no longer required the specified intervention. At the same time, RN #116 indicated to Inspector #655 that information related to resident #003's plan of care – specifically, with regards to continence care, is kept in the resident's care plan and kardex. RN #116 reviewed the resident's care plan and kardex and indicated to Inspector #655 that it had not be updated to reflect the changes in resident #003's care, as it still indicated that resident #003 used the specified intervention which had been discontinued.

The licensee failed to ensure that resident #003's plan of care was revised when the resident's care needs changed or the care set out in the plan was no longer necessary.

ii) The licensee failed to ensure that resident #024's plan of care was revised when the resident's care needs changed or the care set out in the plan was no longer necessary.

Inspector #655 reviewed the health care record belonging to resident #024. According to the resident's plan of care, resident #024 requires assistance with

toileting for a specific reason. In the care plan, it is indicated that resident #024 requires physical assistance with toileting and transfers; and assistance with pericare after each incontinence.

During the inspection, resident #024 indicated to Inspector #655 that staff do not assist them with toileting or transfers. Resident #024 indicated that they are independent and do not require any assistance with toileting or pericare. Resident #024 further indicated that if needed, they would use their call bell to request assistance; however, at the time of the interview, resident #024 could not recall a time when they had required assistance.

During an interview, PSW #138 indicated to Inspector #655 that resident #024 is not often incontinent. At the same time, PSW #138 indicated to Inspector #655 that resident #024 is able to self-navigate to the bathroom from different places in their room, and that at night the resident will self-transfer and self-toilet.

On June 12, 2018, RPN #137 indicated to Inspector #655 that resident #024 is independent with transfers and toileting; and does not require assistance from staff.

The licensee failed to ensure that resident #024's plan of care was revised when the resident's care needs changed or the care set out in the plan was no longer necessary. [s. 6. (10) (b)]

6. The licensee has failed to ensure that when the plan of care had not been effective for resident #022, different approaches were considered in the revision of the plan of care.

Family member #001 expressed concerns over frequent falls sustained by resident #022 and that the homes only intervention was for resident #022 to mobilize using a specified mobility aid. Family member #001 did not believe that other options were explored to manage the resident's falls and the use of the mobility aid would take away resident #022's mobility.

A review of resident #022's care plan found that resident #022 had needs related to falls/balance. It was indicated that the resident had a history of falling and that they were at risk of falls related to an unsteady gait. Five specific interventions were documented in the care plan.

The care plan prior to this had the same five interventions that are noted above for falls/balance.

Resident #022's progress notes were reviewed:

• Notes were documented indicating numerous falls, some of which resulted in hospitalization as a result of the injuries sustained.
• Two physiotherapy entries were documented in 2018, one entry was related to two falls and the other entry was related to a transfer assessment. Neither entry discussed interventions related to falls prevention.
• There were two progress notes related to resident #022 using a the above-noted mobility aid:
o One indicated that the resident's SDM agreed to the use of the mobility aid with certain provisions;
o The other note indicated that resident #022 was at high risk for falls, and that the resident's POA had refused the use of the specified mobility aid. In the same note, it indicated that a care conference had been booked for a specified date to discuss the possibility of using the mobility aid for resident #022.

During an interview with Inspector #593, RN #116 reported that they trialed the mobility aid however the resident did not like it. The RN added that when reviewing changes for the resident related to falls prevention, the interdisciplinary team would get together and see what the best approach was for the resident. This would usually involve the Director of Care (DOC) or the Director of Resident services (DRS).

During an interview with Inspector #593, Physiotherapist (PT) #130 reported they could not locate any physiotherapy assessments for resident #022 in the past 12 months and that there were no referrals located for physiotherapy for this resident in 2018.

During an interview with Inspector #593, the DOC reported that resident #022 had multiple falls and they had been talking to the family about the resident's mobility. The family wanted the Occupational Therapist (OT) to assess the resident. The resident did have specified protective equipment, but these went missing. They had been suggesting the specified mobility aid to the family for some time but they kept refusing. They also suggested a specified type of restraint. The DOC added that a care conference was held with the family and it was discussed again, the possibility of a mobility aid and they believed that a referral to OT was completed and

subsequent OT assessment however the DOC could not locate any documentation related to this.

Resident #022 was at high risk of falls, having sustained numerous falls. The resident was not assessed by the OT or PT for interventions related to falls prevention nor were other interventions discussed with the interdisciplinary team as a result of these numerous falls. The residents care plan was not updated from a specified date despite having sustained numerous falls. [s. 6. (11) (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 when a plan of care is being revised because the care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Inspector #655 reviewed the health care record belonging to resident #007. In an Minimum Data Set (MDS) assessment, resident #007 was identified as exhibiting altered skin integrity. In a progress note entered on a specified date, resident #007 was described as exhibiting altered skin integrity which had required a treatment.

During the inspection, Inspector #655 observed resident #007, accompanied by PSW #132, to have a small sore on a specific body part. PSW #132 indicated to Inspector #655 that on most mornings, resident #007 is found to have blood on their skin in the area of this sore.

Over the course of the inspection, Inspector #655 spoke with a family member of resident #007 who indicated to Inspector #655 that resident #007 had a specific skin condition.

During an interview, RPN #133 indicated to Inspector #655 that a member of the registered nursing staff would assess a resident's skin once a week whenever a resident has an identified skin issue; and for issues that occurred intermittently, would be expected to assess the resident each time it recurred. At the time of the interview, RPN #133 indicated that there was a skin assessment tool available for conducting the skin assessments. RPN #133 indicated to Inspector #655 that they, however, had never used the tool. At the time of the interview, RPN #133 was not sure whether resident #007 was expected to receive a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

During an interview, Director of Resident Services #113 indicated to Inspector #655 that when a resident exhibits a skin tear, or alteration in skin integrity which requires a treatment other than a wound, it is expected that the "Head to Toe" skin assessment tool be used to assess the resident's skin. In the presence of the inspector, Director of Resident Services #113 reviewed the resident's progress notes and found the above-described note. Director of Resident Services #113 indicated to Inspector #655 that based on the information provided in the progress note, it would be expected that resident #007 would have received a skin assessment, using the "Head to Toe" tool at the time that the skin issue was discovered, and then weekly until it resolved.

Inspector #655 was unable to locate any documentation in resident #007's health care record that would demonstrate that resident #007 had received a skin assessment by a member of the registered nursing staff using the "Head to Toe" skin assessment tool, or any other tool at any time in the last two years.

The licensee failed to ensure that resident #007 received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin when resident #007 exhibited altered skin integrity. [s. 50. (2) (b) (i)]

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 resident's exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On a specified date, Inspector #655 observed an unlocked, unattended, medication cart in the hallway near the dining room on the third floor while RPN #117 administered medications in the dining room. At that time, Inspector #655 was able to open the medication cart drawers while the cart was not in the nurses' line of sight.

Inspector #655 spoke with RPN #117 following the above-noted observations. RPN

#117 indicated to Inspector #655 that the medication cart is not regularly locked in between residents during a medication pass as it would be too difficult to lock the cart each time. RPN #117 indicated to Inspector #655 that they would lock the cart if they were further away or in a resident's room.

During the inspection, Inspector #655 observed an Environmental Staff member, #118, to be mopping the floor in the medication room on the second floor. At the time of the observation, the medication room door was left open, with a set of keys hanging from the door lock. Inside the medication room, Inspector #655 observed a basket of prescription ointments. At the time, Environmental Staff #118 indicated to Inspector #655 that the nurse must allow them to enter the medication room; but, that the nurse does not supervise them while cleaning the medication room. At the same time, Environmental Staff #118 indicated to Inspector #655 that the nurse must first remove all of the medications from the medication room.

On the same day, Inspector #655 observed a medication cart in the main lobby area of the second floor (complex care area) to be left unlocked and unattended at 1248 hours. Inspector #655 was able to open the medication cart drawers.

On another day, Inspector #655 observed an unlocked, unattended medication cart in the hallway outside of the dining room on the second floor (complex care area). At the time of the initial observation, no nurse was found to be in the area. During the observation period, RPN #119 returned to the cart briefly; and subsequently was observed to leave the medication cart unlocked and unattended while the nurse was observed to enter the closed nurses' station, where the unlocked medication cart could not be seen. Inspector #655 continued to observe the medication cart for a period of 15 minutes, until RPN #119 was seen to return to the cart and lock it.

On another day, Inspector #655 observed the third floor medication room door to be propped open with a chair. Inspector #655 entered the medication room and found the room was not in use- there was no staff member inside or outside of the medication room. Inside the third floor medication room, Inspector #655 observed an unlocked medication cart. Inspector #655 was able to open all of the medication cart drawers. At the same time, Inspector #655 found an unlocked fridge in the same medication room. Inspector #655 was able to open the fridge and found that it contained Insulin. Inspector #655 remained at the medication room door until staff were notified of the concern. Following the inspector's prompt, an RN was observed to lock and close the medication room door at approximately 1509 hours.

On another day, Inspector #655 conducted several observations on the "Gentle Care" resident home area, a secure unit. At approximately 1110 hours, Inspector #655 observed that the nurses' station door was closed but unlocked. On entering the nurses' station, Inspector #655 found a plastic bin which contained several prescription topical medications, including three containers of Hydrocortisone Acetate 1% ointment, and a container of Hyderm 1% with 0.5% Menthol.

Also on the "Gentle Care" resident home area, a secure unit, Inspector #655 observed a medication cart to be left unlocked and unattended at approximately 1220 hours. The medication cart was left in the hallway outside the dining room. At the same time, several drawers of the medication cart were observed to be left ajar (including the 2nd, 3rd, and 5th drawers from the top). Inspector #655 continued to observe the cart during a medication pass. A nurse was observed to return to the cart and subsequently leave to administer medications to various residents in the dining rooms. Each time, it was observed that the medication cart was left unlocked, with several doors left ajar, in between residents. Over the course of the observation period, the medication cart was not consistently supervised by a staff member.

Immediately following the above-noted observations, Inspector #655 spoke with RPN #123 who identified themselves as an agency nurse. RPN #123 indicated to Inspector #655 that because they were from an agency, they were not familiar with the licensee's expectations for ensuring that medications in the medication cart are kept secure.

Over the course of the inspection, RN #107 indicated to Inspector #655 that medication carts are expected to be closed and locked at all times - including during a medication administration pass, in between residents. RN #107 indicated that this was particularly important in the "Gentle Care" area, given the resident population in that area. At the same time, RN #107 indicated that housekeeping staff are expected to be supervised by a member of the registered nursing staff when they are cleaning the medication room.

During an interview, DOC #124 indicated to Inspector #124 that it was not practical to lock medication carts in between each resident during a medication pass. At the same time, DOC #124 indicated that when a nurse is administering a medication to a resident during a medication pass, they would be unlikely to be able to supervise

the medication cart consistently at all times.

The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in a locked area or stored in a separate locked area within the locked medication cart.

During the inspection, Inspector #655 conducted an observation of a morning medication pass on the third floor. On arrival to the third floor, Inspector #655 found that a medication cart was left unlocked and unattended outside the dining room. Shortly after, RPN #120 was observed to administer medications, including a specified controlled substance to a specific resident. During the observation, Inspector #655 observed that RPN #120 removed a blister pack containing the resident's supply of the controlled substance, from a drawer in the medication cart (the 4th drawer down from the top), where the supply was not double-locked. At the same time, Inspector #655 observed several other blister packs to be stored in the same location.

During an interview immediately following the above-noted observations, RPN #120 indicated to Inspector #655 that their regular practice was to remove residents' blister packs which contain controlled substances from the separate locked area in the bottom drawer of the medication cart (where the controlled substances could be double-locked) and to place them in the above-noted drawer for ease of access during the medication passes. RPN #120 indicated to Inspector #655 that in doing so, they do not have to use a key to lock and/or access the controlled substance for each individual resident during a medication pass.

During the inspection, Inspector #655 observed a count of controlled substances, performed by two members of the registered nursing staff at shift-change (RPN #120 and RPN #121). During the count process, RPN #120 was observed to remove a vial from the fridge in the medication room. The vial was not observed to be stored in a separate locked container in the fridge; nor was the fridge observed to be locked. At the time of the observation, RPN #120 indicated to Inspector #655 that the vial from the fridge contained injectable Lorazepam, a benzodiazepine and controlled substance.

During the same observation period, Inspector #655 observed RPN #120 to waste

an amount of Hydromorphone injectable. According to RPN #120, the amount of Hydromorphone injectable that remained in the vial was 0.5 ml. RPN #121 was observed to serve as a witness. Inspector #655 observed RPN #120, in the presence of RPN #121, to place the vial which reportedly contained 0.5 ml of Hydromorphone into a yellow sharps container attached to the medication cart where it was not observed to be double-locked.

During an interview immediately following the above-noted observations, RPN #120 indicated to Inspector #655 that the injectable Lorazepam is to be stored in the fridge in the medication room, in accordance with pharmacy direction. At the same time, RPN #120 indicated to Inspector #655 that the fridge in the medication room did not lock; and that the vial of Lorazepam had been stored in the fridge for as long as they had worked there.

During an interview on the same day, RN #122 indicated that all wasted medications are to be disposed of in the yellow "sharps" container that is attached to the medication cart.

Over the course of the inspection, RN #107 indicated to Inspector #655 that all controlled substances are expected to be double-locked at all times.

During an interview, DOC #124 indicated to Inspector #655 that controlled substances are expected to be double-locked at all times when in the medication cart (requiring that both the medication cart, and the separate container for storing controlled substances within the medication cart are locked). At the same time, DOC #124 indicated to Inspector #655 that disposing of wasted medications – specifically of controlled substances, in the yellow sharps container attached to the medication cart is not consistent with expectations. DOC #124 further indicated to Inspector #655 that where a controlled substance must be stored in the fridge, it is expected to be stored on the second floor where the substance can be double-locked in a separate storage container inside the fridge in the locked medication room.

In addition to the above-described findings, refer to part 1 of WN #6, where medication carts were observed to be left unlocked and unattended on multiple occasions over the course of the inspection; at which times, any controlled substances that were stored in the medication carts would not have been double-locked.

The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in a locked area or stored in a separate locked area within the locked medication cart. [s. 129. (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 drugs are stored in an area or a medication cart that is secure and locked; and to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in a locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident equipment is kept clean and sanitary.

On a specific date, Inspector #573 observed the wheelchair belonging to resident #002 to be unclean, with an unknown dried material found to be on the wheelchair frame, leg support and brakes.

Two days later, Inspector #655 observed the wheelchair belonging to resident #002. At the time of the observation, Inspector #655 also found the wheelchair to be unclean, with dried stains on the wheelchair frame, and a dried substance on the foot pedals.

Inspector #655 reviewed the cleaning schedule for resident walkers and wheelchairs on resident #002's resident home area. According to the schedule, resident #002's wheelchair was to be cleaned later that day.

The day after resident #002's wheelchair was to be cleaned, PSW #131 accompanied Inspector #655 to observe the wheelchair belonging to resident #002, at which time the resident's wheelchair remained unclean. PSW #131 indicated to Inspector #655 that stains and debris that were found on resident #002's wheelchair would be expected to have been cleaned by the night shift PSWs. According to PSW #131 night PSW staff are expected to take everything off of the wheelchair, including the seat cushion cover, in order to wash it. PSW #131 further indicated, however, that PSWs who are working days are also expected to clean resident wheelchairs as needed, whenever they are observed to be unclean. Over the course of the inspection, RPN #106 and DOC #124 indicated the same.

Inspector #655 continued to observe the wheelchair belonging to resident #002 over the course of the inspection. Resident #002's wheelchair was found to be unclean on two other specified days.

The licensee failed to ensure that resident #002's wheelchair was kept clean and sanitary. [s. 15. (2) (a)]

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a Personal Assistance Service Device (PASD) under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if, the use of the PASD has been consented to by the resident or, if the resident is incapable, a Substitute Decision-Maker (SDM) of the resident with authority to give that consent.

In accordance with LTCHA 2007, s. 33 and O. Reg 79/10, s.111, a PASD is a device used to assist a person with a routine activity of living that limits/ inhibits freedom of movement and which the resident is unable to physically or cognitively remove. The licensee shall ensure that for those residents using devices as PASDs, under section 33 of the Act, the use of the PASD is reasonable and that consent has been obtained and documented from the resident or by the resident's substitute decision maker.

(i) During the inspection, Inspector #573 noted resident #007's bed system with two rotary side rails. Inspector observed that the bed rail on the right side was placed in horizontal position and the bed rail on left side was placed in vertical position.

On the same day of the above-noted observation, Inspector #573 spoke with PSW #103, who indicated that two bed rails were used for resident #007 for specific reasons. Further, PSW #103 indicated that both bed rails will be placed in horizontal position when resident #007 is in bed.

Inspector #573 reviewed resident #007's written plan of care in place which included directions to staff related to the use of bed rails for resident #007.

During an interview with Inspector #573, RPN #104 indicated that the two rotary side bed rails were used to assist resident #007 with specific needs. The RPN #104 indicated to the inspector that the two bed rails were used as a PASD. Further, RPN #104 indicated that resident #007 was physically unable to release the bed rails on their own.

Inspector #573 reviewed resident #007's health care record with the RPN #104 and there was no consent that was obtained and documented regarding the use of two rotary bed rails as a PASD either from the resident or from the resident's SDM.

(ii) During the inspection, Inspector #573 noted resident #004's bed system with two rotary side rails.

Inspector observed that the bed rail on the left side was placed in horizontal position and the bed rail on the right side was placed in vertical position.

Inspector #573 spoke with PSW #105, who indicated that two bed rails were used for resident #004 for a specific reason. Further, PSW #105 indicated that both the

bed rails will be placed in horizontal position when resident #004 is in bed.

Inspector #573 reviewed resident #004's written plan of care in place which included direction to staff related to the use of bed rails for resident #004.

During an interview with Inspector #573, RN #107 indicated that staff were directed to use both side rails for resident #004. RN #107 indicated to the inspector that the two bed rails were used as a PASD. Further, RN #107 indicated that resident #004 was physically unable to release the bed rails on their own.

Inspector #573 reviewed resident #004's health care record with RN #107 and there was no consent that was obtained and documented regarding the use of two rotary bed rails as PASD either from the resident or from the resident's SDM. [s. 33. (4) 4.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that personal items acquired by residents were labelled within 48 hours of acquiring the new items.

During the initial tour of the home May 28, 2018, Inspectors #593 and #573 observed multiple personal items in the shared resident tub/shower rooms that were not labelled. These items included combs, disposable razors, deodorant sticks and hairbrushes. These items were observed to have been used.

On June 6, 2018, Inspector #593 observed multiple personal items in the shared resident tub/shower rooms on the second and third floors, including nail clippers, deodorant sticks, a hairbrush, a disposable razor, one electric razor, and three combs. All items appeared to have been used.

On June 6, 2018, Inspector #593 found multiple used personal items that were not labeled in three shared resident washrooms. Among the unlabeled personal items found in these washrooms were: a set of nail clippers, a disposable razor, eight combs, seven toothbrushes, and two hairbrushes. All items appear to have been used.

During an interview with Inspector #593, PSW #111 was unsure of who the used items in the tub/shower room belonged to. PSW #111 further explained that the usual process was that each resident had their own personal care items which were kept in their own washroom cabinet. These were not labeled as most of the residents on this floor knows what belonged to them.

During an interview with Inspector #593, PSW #112 reported that they were unsure why personal items were left in the tub/shower room however these items were not supposed to be left in the tub/shower room. PSW #112 further explained that each resident had their own personal care items that were labeled and kept in their washroom cabinet.

During an interview with Inspector #593, Director of Resident Services #113 reported that personal items were supposed to be labeled with the residents name. Any items used in the shared tub/shower rooms should be taken back to the resident's room when the resident has finished bathing. Director of Resident Services #113 further explained that items in shared washrooms also need to be labelled. [s. 37. (1) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #003's pain was not relieved by initial interventions, they were assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

As described in WN # 1, resident #003 reported during the inspection that they experienced chronic pain; and indicated to Inspector #593 that although a specified medication for pain was being given, they continued to experience pain.

Inspector #593 reviewed the health care record belonging to resident #003. According to the residents care plan, resident #003 had pain in a specific body area related to a medical condition. Resident #003's plan of care was found to include orders for routine and "PRN" (as needed) medications. The inspector reviewed the resident's MARs for five separate months. According to resident #003's MARs, resident #003 was given a specified PRN medication for pain 23 times in the first month; 20 times in the second month; 14 times in the third month; 8 times in the fourth month; and, one time in the fifth month.

A review of resident #003's progress notes for a four month period found numerous entries related to resident #003 complaining of pain, and requiring a PRN medication for pain management. Resident #003's e-Assessments in Med e-Care were reviewed and the last completed pain assessment was from over a year ago.

As described in WN #1, RN #107 was interviewed by Inspector #593. According to RN #107, in addition to routine pain assessments conducted for all residents, a pain assessment is to be completed whenever a resident's chronic pain is not being managed by their regular prescribed medications. RN #107 further indicated that pain assessments are to be completed when a resident starts to ask for more PRNs. RN#107 was unable to locate a completed pain assessment for resident #003 that was more recent than the above-noted assessment completed over a year ago. The RN was not aware of the PRN usage for this resident; however, when they reviewed the resident's MAR for a specified month, the RN's response was "I guess we will complete a pain assessment then".

During an interview with Inspector #593, Resident Care and Informatics Manager (RCIM) #109 reported that based on the home's policies and procedure, a pain assessment should be completed upon admission, readmission, quarterly, any significant change, if pain medications are given and not effective, if there is an increase in the use of PRN medication for breakthrough pain or if the residents pain scale is over two.

The licensee has failed to ensure that when resident #003's pain was not relieved by initial interventions, they were assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

During the inspection, a representative of the Family Council indicated to Inspector #655 that the Family Council did not have an opportunity to review the satisfaction survey or to provide any feedback with regards to the satisfaction survey before it was distributed. At the same time, the representative of the Family Council indicated to Inspector #655 that there were questions in the satisfaction survey that were poorly structured.

During the inspection, Administrator #134 indicated to Inspector #655 that it is a corporate designed satisfaction survey which is distributed in the home. Administrator #134 explained to Inspector #655 that from one survey to the next (between distributions of the same survey), the Family Council would have opportunity to notify them if there were any concerns related to the survey; and, according to Administrator #134 no concerns had been brought forward. On the same day, Administrator #134 indicated to Inspector #655 that they did not recall specifically asking the Family Council for feedback with regards to the satisfaction survey. With regards to seeking the advice of Family Council on acting on the results of the satisfaction survey, Administrator #134 indicated that the results get posted in the home where the Family Council members would have access to them. Administrator #134 further explained that they had not been invited to attend a Family Council meeting to discuss the satisfaction survey, and therefore they could not do so.

The licensee failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that the following order made under this Act was complied with.

A Compliance order was served to the home on January 29, 2018, pursuant to O.Reg 79/10, s. 55. Every licensee of a long-term care home shall ensure that, (a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents. The order was to be complied with by April 27, 2018.

The licensee was ordered to:

Develop and implement a plan to ensure that the Director of Care and/or delegate, will implement a monitoring process to observe, document and attest that the home's revised policy and procedure titled "Behavioural Interventions- LTC-RCM-F-10.20," is understood and applied by the nursing staff on all three shifts. This process will be conducted a minimum of weekly for four weeks and when staff are deemed to be compliant by the Director of Care and/or delegate, this will be followed by a minimum of monthly checks for three months and when staff are deemed to be compliant by the Director of Care and/or delegate, this will be followed by a reassessment of the frequency of checks and any modifications necessary, to ensure compliance, by the home's Administrator in collaboration with the Director of Care and/or delegate.

During an interview with Inspector #593, the DOC reported that the policy and procedure titled "Behavioural Interventions- LTC-RCM-F-10.20," was reviewed with nursing staff. The resident care plans were also being reviewed on a weekly basis

to ensure that the care plan was being followed. It was the Resident Care and Informatics Manager that oversees this process.

During an interview with Inspector #593, the Resident Care and Informatics Manager (RCIM) reported that new interventions related to responsive behaviours were updated in the care plan and they ensured that nursing staff were aware of the new interventions. It was discussed every two weeks as to whether the interventions were being followed and working however there had been no weekly monitoring of this process or documenting of this process.

As reported by the DOC and the RCIM, a process was implemented to monitor the care plans related to responsive behaviours and the responsive behavior policy however this process was not documented as per the compliance order served January 29, 2018. [s. 101. (3)]

WN #13: 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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
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).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that a medication incident in respect of which a resident was taken to hospital was reported to the Director no later than one business day after.

A Critical Incident Report (CIR) was submitted to the Director under the Long-Term Care Homes Act, 2007, on a specified date. The incident report was related to the improper treatment of resident #026, resulting in harm or risk of harm to the resident. According to the CIR, medication reconciliation orders were incomplete by the RN upon resident #026's admission to the home, resulting in multiple drug omissions. In the CIR it is further indicated that resident #026 was transferred to the hospital on a specified date; and admitted to the hospital the following day.

Inspector #655 reviewed the health care record belonging to resident #026. According to the health care record, resident #026 was admitted to the home on a specified date; at which time a MEDREC form was prepared for resident #026, and the above-noted omissions occurred.

Inspector #655 reviewed the medication incident report related to the above-described incident. On the medication incident report, the CI date is identified as a specified date. Within the report it is indicated that the incident occurred at the time of the resident's admission to the home; and that the incident was first reported to an RPN by a family member of resident #026 six days before the CIR was submitted to the Director under the Long-Term Care Homes Act.

There was no indication that the after-hours pager was used for reporting of the incident at any time.

The licensee failed to ensure that a medication incident in respect of which a resident was taken to hospital was reported to the Director no later than one business day after. [s. 107. (3)]

2. The licensee has failed to ensure that a required report was made in writing related to an incident under subsection 3.1, setting out the following with respect to the incident: i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence.

A CIR was submitted to the Ministry of Health and Long Term Care (MOHLTC) on a specified date, reporting that a resident sustained a fall resulting resulting in a specified injury. Under analysis and follow-up, the home documented in the CIR, "will await residents return from hospital to discuss with (them) and family interventions to prevent this type of incident".

An amendment request was made by CIATT related to the immediate and long-term actions implemented after the incident 15 days after the CIR was submitted, at which time the resident had returned to the home from hospital. However, at the time of this inspection, there was no amendment made to the CIR. [s. 107. (4) 4.]

Issued on this 20 day of September 2018 (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

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by MICHELLE EDWARDS (655) - (A1)

Inspection No. / No de l'inspection : 2018_597655_0013 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 009583-18 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Sep 20, 2018;(A1)

Licensee / Titulaire de permis : Villa Marconi Long Term Care Center
1026 Baseline Road, OTTAWA, ON, K2C-0A6

LTC Home / Foyer de SLD : Villa Marconi
1026 Baseline Road, OTTAWA, ON, K2C-0A6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Gaetan Grondin

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 Villa Marconi Long Term Care Center, 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:

1. Review and revise the policies related to the processes of medication reconciliation and how to conduct a best possible medication history to ensure that there are clear directions, and that they are consistent with best practices or, if there are none, with prevailing practices.

2. Ensure that all registered nursing staff are trained on the revised policies. Attendance records are to be maintained related to this training.

3. Ensure that the following written policies and protocols developed for the medication management system under s. 114 (2) of Ontario Regulation 79/10 are complied with:

- "Medication Reconciliation" (Policy Number LTC-NAM-F-10.40), effective January, 2015,
- "Medication Reconciliation – Long Term Care Homes Used Med e-Care"

(Policy Number 9.6),
- "Medication Reconciliation- Long Term Care Homes" (Policy Number 2.7.1), revised December, 2016,
- "Medication Management – Security & Storage" (Policy Number LTC-NAM-F-10.20), effective January, 2015,
- "Safe Storage of Medications" (Policy Number 4.8), revised July, 2014,
- "Sharps Containers and Disposal" (Policy Number: 6.4), revised July, 2014,
- "Medication Management System Evaluation" (Policy Number: LTC-NAM-F-10.10), effective January, 2015; and,
- "Reporting Medication Incidents" (Policy Number 7.3), revised July, 2014.

4. Develop and implement monitoring and remedial processes:

(a) At a minimum, adherence to the policies by nursing staff will be measured on a weekly basis on all units for a period of four consecutive weeks.

(b) The licensee shall ensure that corrective action is taken if deviations are identified; and,

(c) A written record is kept of everything required under (a) and (b).

The compliance due date for CO #001 is October 12, 2018.

Grounds / Motifs :

1. The licensee has failed to ensure that policies related to the medication management system were complied with.

In accordance with Ontario Regulation 79/10, s. 114 (2), the licensee was required to have written policies and protocols 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.

1. Medication Reconciliation

Specifically, the licensee has failed to ensure that the following policies and protocols related to medication reconciliation were complied with:

- "Medication Reconciliation" (Policy Number LTC-NAM-F-10.40), effective January, 2015,
- "Medication Reconciliation – Long Term Care Homes Using Med e-Care" (Policy Number 9.6); and,
- "Medication Reconciliation- Long Term Care Homes" (Policy Number 2.7.1), revised December, 2016.

Inspector #655 reviewed all three of the above-identified policies related to medication reconciliation; and, over the course of the inspection reviewed the medication reconciliation process with RN #107, a pharmacy representative, DOC #124 and Director of Resident Services #113.

According to the licensee's policies, the medication reconciliation process includes the following steps:

- The nurse is to create a best possible medication history (BPMH) from all possible sources, during which time the resident and/or resident's family would be interviewed.
- The nurse is to document the BPMH obtained in the spaces provided on the Medication Reconciliation and Admission Order (MEDREC) form, indicating for each medication: the medication name, strength, dose, route of administration, frequency, and indication for use, if known at the time of admission from a reliable medical source.
- The nurse is to identify all relevant sources used to create the BPMH from the list of options that are provided in the upper right-hand corner of the MEDREC form.
- Various orders are to be compared while monitoring for any discrepancies. When there is a discrepancy, the nurse is to document the details of the discrepancy in the comments section next to the medication order on the MEDREC form; resolve identified discrepancies with the most appropriate health care professional, document the resolution details on the form, and make any necessary adjustments to the medication orders.
- The MEDREC form is then to be signed and dated by the nurse who is responsible for preparing the form; and the resident's attending physician is contacted.
- The physician assesses the nurse prepared medication profile as recorded on the MEDREC form (and any supporting documents as applicable); and then provides direction to "continue", "discontinue", or "hold" each listed medications. This is to be documented on the MEDREC form first by checking the appropriate box ("continue", "discontinue", "hold") for each order.

- For risk management purposes, the nurse is then required to clearly cross out all discontinued orders and clearly identify any held orders on the MEDREC form. Any additional orders (i.e. lab work), are also to be documented in the appropriate section (s) on the form, as applicable.

According to the licensee's policies, the medication reconciliation process it to be completed within 24 hours of each resident's admission or readmission to the home. When a resident is readmitted to the home, all prior orders are to be documented as discontinued. It is further stated in policy that the medication orders are to be "first" and "second checked" by two different nurses', at which time the available source documents are to be reviewed as applicable. The first and second checks are to be documented in the spaces provided on the bottom of the MEDREC form. The spaces are labeled "Nurse Signature First Check By" and "Nurse Signature Second Check By", respectively.

A) The licensee's medication reconciliation policies were not complied with when resident #026 was admitted to the home on a specified date. In this case, the failure to comply with the medication reconciliation policies lead to a medication error which reached the resident and resulted in a negative outcome.

>Resident #026:

A Critical Incident Report (CIR) was submitted to the Director under the Long-Term Care Homes Act, 2007, on a specified date. The incident report was related to the improper treatment of resident #026, resulting in harm or risk of harm to the resident. According to the CIR, medication reconciliation was incomplete by the RN (RN #107) upon resident #026's admission to the home (on a specified date), resulting in multiple drug omissions. It is indicated in the CIR that resident #026 was transferred to the hospital on a specified date, just over a month after the resident was admitted to the home; and, was admitted to the hospital the following day, at which time the error was discovered. As such, multiple drug omissions occurred between a period of almost five weeks. This incident is further described in WN #2.

Over the course of the inspection, Inspector #655 found that the medication reconciliation process was not completed in accordance with the licensee's policies when resident #026 was admitted to the home on a specified date. The policies were not complied with in the following ways:

(a) An order which was to be discontinued at the time of admission was identified as such using a check-mark in the box labeled "discontinued" on the MEDREC form; however, it was not clearly crossed out as required by policy for risk management purposes and as indicated in a tip sheet.

(b) Not all medications and other interventions were transcribed from the admission medication list sources onto the MEDREC form as required by the licensee's policies (See WN #2). In addition to the medications that had not been transcribed onto the MEDREC form, the need for another specified intervention was identified on the community pharmacy medication list, but was not found on the MEDREC form.

(c) The accuracy of the information documented on the MEDREC form was not verified by another nurse. On review of the MEDREC form, Inspector #655 found no signatures in the spaces labeled "Nurse Signature First Check By" and "Nurse Signature Second Check By", respectively, located at the bottom of the MEDREC form. On a "Medication Incident Report & Analysis Form" related to the same incident, it is also indicated that the medication reconciliation prepared by RN #107 had not been verified by another nurse. During interviews, both RN #107 and DOC #124 confirmed that the medication reconciliation was not verified by another nurse when resident #026 was admitted to the home as required by the licensee's policies (See WN #2).

(d) The medication list source documents were not identified on the MEDREC form as required by the licensee's policy and as indicated in the medication reconciliation tip sheet.

(e) Resident #026's family – and specifically, their substitute decision maker (SDM), was not involved in the medication reconciliation process. (See WN #4)

Based on the above-described findings, the medication process was not fully completed within 24 hours of resident #026's admission to the home. Moreover, the process was not ever fully completed during the time that resident #026 resided in the home (a period of almost five weeks).

The licensee failed to ensure that the following medication reconciliation policies were complied with when resident #026 was admitted to the home on a specified date: "Medication Reconciliation" (Policy Number LTC-NAM-F-10.40), effective January, 2015; "Medication Reconciliation – Long Term Care Homes Using Med e-

Care" (Policy Number 9.6); and, "Medication Reconciliation- Long Term Care Homes" (Policy Number 2.7.1), revised December, 2016, as well as the identified companion documents.

B) Over the course of the inspection, Inspector #655 found that the licensee's medication reconciliation policies were also not complied with when: resident #037 was admitted to the home on a specified date; when resident #034 was readmitted to the home on a specified date; and, when resident #033 was admitted to the home on a specified date. In each of these three cases, the failure to comply with the medication reconciliation process itself did not have a direct impact on the resident.

>Resident #037:

The licensee's medication reconciliation policies were not complied with when resident #037 was admitted to the home on a specified date.

A medication incident involving resident #037 was reported to Inspector #655 during the inspection by a representative of the pharmacy service provider. The incident involved resident #037 and involved a transcription error which occurred during the medication reconciliation process when resident #037 was admitted to the home on a specified date. At that time, a specified medication was not transcribed onto the MEDREC form. As a result, resident #037 did not receive the previously prescribed medication for a period of approximately 11 weeks. See WN #2 for additional information related to this incident.

Inspector #655 reviewed the MEDREC form dated the date of resident #037's admission, also prepared by RN #107. On review of the form, Inspector #655 found that the licensee's policies related to medication reconciliation had not been complied with in the following ways:

a) The above-noted specified medication had not been transcribed onto the form,
b) The medication list sources were not identified,
c) A medication identified as one to be discontinued was not clearly crossed out, as required by policy for risk management purposes.

>Resident #034:

Over the course of the inspection, Inspector #655 was made aware of another

incident related to a transcription error which occurred during the medication reconciliation process upon resident #034's readmission to the home from the hospital. The incident occurred on a specified date; and, was discovered ten days later. The error did not reach resident #034.

As described in WN #3, Inspector #655 reviewed the "Medication Incident Report and Analysis Form" for resident #034 as well as the resident's health care records. Based on the review, it was determined that the medication reconciliation policies were not complied with when resident #034 returned to the home on a specified date in the following ways:

a) Not all medications identified on the readmission medication source lists (hospital discharge summary and hospital prescriptions) were transcribed onto the MEDREC form in order to resolve discrepancies. On the discharge summary printed on a specified date, there was a prescription for a specific medication to be given when needed in a specified dose and frequency. In another hospital prescription document that was printed one day prior, there was no indication that resident #034 had been prescribed the specified medication in the above-noted dose and frequency. The specified medication, in the above-listed dose and frequency was not transcribed onto the MEDREC form completed for resident #034.

b) Not all pre-hospital medications were documented on the MEDREC form or identified as medications to be discontinued. Two of the pre-hospital medications remained on resident #034's MAR when resident #034 returned to the home from the hospital on a specified date for a period of eight days.

c) There was no indication on the MEDREC form as to who prepared the MEDREC form.

d) Medications that were identified as being medications to be discontinued were not clearly crossed out, as required by policy for risk management purposes.

> Resident #033:

Over the course of the inspection, Inspector #655 reviewed the health care records, including the MEDREC form and the related medication list sources found for resident #033 who was admitted to the home on a specified date.

On review of resident #033's MEDREC form, Inspector #655 found that the medication reconciliation policies had not been complied with in the following ways:

a) Two medications were identified as being medications that were to be discontinued. This was indicated on the form by a check-mark which was placed in the "discontinued" box associated with each of the noted orders. There was no other documentation to indicate that the two medications were to be discontinued. They were not clearly crossed out, as required by policy for risk management purposes.

b) The route of administration was not recorded for two specific medications.

c) The dose was not recorded for two specific medications.

d) The frequency of administration was not documented for two specific medications.

e) The medication list sources were not identified on the MEDREC form.

At the time of the inspection, Inspector #655 was not aware of any medication incidents involving resident #033, related to the above-noted findings. According to the documentation on the MEDREC form, the medication reconciliation form in this case was also completed by RN #107.

The licensee's medication reconciliation policies were not complied with when: resident #037 was admitted to the home on a specified date; when resident #034 was readmitted to the home on a specified date; or when resident #033 was admitted to the home on a specified date.

C) In addition to the above-described findings, Inspector #655 found that issues related to compliance with the licensee's medication reconciliation policies were previously known.

During the inspection, Inspector #655 reviewed a copy of the "Service Delivery Committee" meeting minutes. Attached to the minutes was a document titled "Clinical Consultant Pharmacist Annual Summary for 2017". In this document it is stated that "medication reconciliation audits score have dropped considerably in the last quarter of 2017". In another attached document titled "Supplementary Medication Management Process Review" for "Quarter 4 (Oct-Nov-Dec) 2017" the above-described decline in medication reconciliation audit scores is depicted in a

graph. Next to the visual graph, the following comments were written:

If a discrepancy is noted while completing the medication reconciliation, "it is important to transcribe all orders on the reconciliation form. After clarifying with the physician, the order that should be discontinued would be marked as such. Also, remember that 2 nursing staff should be completing a verification after the physician has authorized reconciliation".

Issues related to compliance with the home's medication reconciliation policy and procedure had been previously identified and shared with the "Service Delivery Committee" before the above-identified instances in which staff failed to comply with the medication reconciliation processes, and before the incident occurred involving resident #026.

2. Other Policies Not Complied With

Over the course of the inspection, Inspector #655 reviewed several other policies related to the medication management system, including:

- "Medication Management System Evaluation" (Policy Number: LTC-NAM-F-10.10), effective January, 2015,
- "Reporting Medication Incidents" (Policy Number 7.3), revised July, 2014,
- "Medication Management – Security & Storage" (Policy Number LTC-NAM-F-10.20), effective January, 2015,
- "Safe Storage of Medications" (Policy Number 4.8), revised July, 2014; and,
- "Sharps Containers and Disposal" (Policy Number: 6.4), revised July, 2014.

As a result of the inspection, it was determined that the above-noted policies were also not complied with. See WN #3 and WN #6 for additional information.

The above-described findings related to policies of the medication management system in the home were widespread. For this reason, the scope of the issue was determined to be a level 3. The severity of this issue was determined to be a level 3 as there was actual harm to a resident related to non-compliance with the licensee's medication policies. As such, a compliance order (CO) will be issued. [s. 8. (1) (b)] (655)

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

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

Nov 07, 2018(A1)

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. 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:

1. Ensure that resident #'s 032, 033, 036, and 037; as well as all newly admitted and readmitted residents receive their prescribed medications, in accordance with the directions for use specified by the prescriber.

2. Direct all registered nursing staff to review the College of Nurse of Ontario (CNO)'s "Medication Practice Standard" at http://www.cno.org/globalassets/docs/prac/41007_medication.pdf ; and, "Medication Decision tool" at http://www.cno.org/en/learn-about-standards-guidelines/educational-tools/decision-tool-medication/. All registered nursing staff are to sign off on the review.

3. Ensure that registered nursing staff receive training related to best practices (and/or prevailing practices) for safe and accurate medication administration. Training records must be maintained in order to demonstrate compliance.

The compliance due date for CO #002 is September 18, 2018.

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.

Over the course of the inspection, Inspector #655 was made aware of five medication incidents involving a resident (resident #033, #026, #032, #036, and #037, respectively). In each of the five incidents, at least one drug was not administered to the identified resident in accordance with the directions for use specified by the prescriber.

>Resident #033:

The licensee failed to ensure that drugs were administered to resident #033 in accordance with the directions for use specified by the prescriber.

According to the medication incident report related to the above-noted incident, resident #033 requested a specified medication on a specified date, which was to be given on an as needed basis. It is indicated on the medication incident report that resident #033 had two medications contained in similar packaging in their medication supply box; and, at the time of the, incident, the RPN (an agency nurse) who responded to the resident's request for the specified medication, used the other medication in error. According to the medication incident report, within several minutes of the error, resident #033 complained of adverse affects and required further assessment at an external health center.

In a progress note, it is indicated that the agency nurse on duty at the time had reported a medication error to RN #116, as it is described above. In the same progress note, resident #033 is described as having experienced adverse affects. Following the incident, resident #033 was treated for the symptoms that were a result of the error.

During an interview, RPN #121 described the medication incident involving resident #033 as it was reported to them during a shift-report, and as it was described above. Over the course of the inspection, DOC #124 confirmed the same.

The licensee failed to ensure that drugs were administered to resident #033 in accordance with the directions for use specified by the prescriber.

>Resident #026:

The licensee failed to ensure that drugs were administered to resident #026 in accordance with the directions for use specified by the prescriber.

A Critical Incident Report (CIR) was submitted to the Director under the Long-Term Care Homes Act, 2007, on a specified date. According to the CIR, medication reconciliation orders were incomplete by the RN upon resident #026's admission to the home, resulting in multiple drug omissions. It is indicated in the CIR that resident #026 was transferred to the hospital on a specified date; and admitted to the hospital the following date. It is further indicated that a member of the registered nursing staff was informed by a member resident #026's family two days after the resident had been admitted to the hospital, that resident #026 had suffered from a specific medical complication.

According to the related medication incident report, when resident #026 was admitted to the home, not all of their medications were transcribed, nor communicated to the physician. On the same incident report, six specific medications were identified as having been omitted.

Inspector #655 reviewed the health care record belonging to resident #026. According to the health care record, resident #026 was admitted to the home on a specified date with multiple diagnoses including one diagnosis that posed a risk for the above-noted medical complication, and for which one of the omitted medications would have been prescribed.

On the resident's MEDREC form (dated the date of resident #026's admission to the home), seven medication orders were listed. Of the initial seven medication orders listed, one was identified as an order to be discontinued at the time of the residents' admission. That is, on admission to the home, and as a result of the mediation reconciliation process, a total of six medications were ordered for resident #026.

On review of the admission medication list sources available in resident #026's health care record, eight other medications which were not captured on the above-described MEDREC form were identified by Inspector #655. For one of the eight identified medications, the clinical indication was recorded as being for prevention of the above-noted medical complication on the admission medication list sources.

Inspector #655 reviewed the physician order's and MARs for resident #026 for a period of two months. There was no indication that an order had been written at any time for resident #026 for three specific medications that had not been included on the MEDREC form, including the medication that was previously prescribed for the prevention of the specified medical complication.

On both of resident #026's MARs reviewed by Inspector #655, the specified medication previously prescribed for the prevention of the medical complication was listed under the "alerts" section. However, there was no indication on either MAR that this medication was otherwise included in the plan of care for resident #026 at any time; and specifically, no indication that resident #026 had received this medication at any time following admission to the home. There was also no indication that resident #026 had received another specified medication which was missed on the MEDREC form at any time following the resident's admission to the home.

In a progress note entered by RPN #128 on the day that the resident was admitted to the hospital, it is indicated that a staff member at the hospital called to inquire about why the specified medication used for the prevention of the specified medical condition had been discontinued for resident #026. According to the note, at that time, RPN #128 informed the caller that resident #026 was allergic to it. In a note entered on the same day by RPN #128, it is further indicated that, according to resident #026's health care record, resident #026 "is on alert (allergic)" to the specified medication.

In a note written by the physician on the same day, in the multidisciplinary progress notes, it is stated that resident #026 was in hospital on that day. In the same note, it is indicated that resident #026 had a specific diagnosis and had been on medication for this diagnosis before; though the medication was not listed on the drug regimen upon admission to the home.

During an interview, RN #107, indicated to Inspector #655 that when resident #026 was admitted to the home, they had completed the admission process for resident #026, including the medication reconciliation process. RN #107 indicated to Inspector #655 that at the time of the admission, resident #026 was known to have multiple diagnoses including a condition which put resident #026 at risk for experiencing the specified medical condition. RN #107 also recalled that they had noted an "alert" in the resident's health care record related to the specified medication that was previously prescribed for resident #026, used to prevent the specified medical condition from occurring. RN #107 indicated to Inspector #655 that they were "confused" by the alert, and did not have a chance to determine its meaning.

During the same interview, RN #107 indicated to Inspector #655 that in transcribing the medications listed on the resident's admission records onto the MEDREC form, they had overlooked some of the medications, explaining that they had copied only the first half of the medications listed on the community pharmacy medication list. According to RN #107, three medications were missed as a result.

During the inspection, Consultant Pharmacist #127 indicated to Inspector #655 that the medication, the specified medication had an "alert" associated with it in resident #026's health care records because it was considered to be a high-alert medication due to the risk of harm associated with the medication, if there is a mistake made with it. Consultant Pharmacist #127 indicated to Inspector #655 that a resident who received an additional dose of the specified medication would be at risk of

developing a specific symptom; and, that if a resident's dose was skipped, the resident would be at risk of developing a specific condition or complication.

During the inspection, Inspector #655 spoke with a family member of resident #026. According to the family member of resident #026, resident #026 was known to have a specific medical condition and, for this reason, was receiving a specified medication. The family member of resident #026 indicated to Inspector #655 that the medication in question had been prescribed by the residents' physician over a year ago; and that there was no indication that this medication was to be discontinued. At the time of the interview, the family member of resident #026 indicated to Inspector #655 that following the resident's recent hospitalization, they had learned that resident #026 had not received the prescribed medication at any time since they were admitted to the long-term care home – a period of almost five weeks. The family member of resident #026 further indicated to Inspector #655 that resident #026 had since suffered a specific medical complication; and that they thought it was the consequence of an omission error involving the specified medication.

Over the course of the inspection, DOC #124 indicated that three specific medications were not identified on the MEDREC form and as a result were not administered to resident #026. DOC #124 confirmed that all three medications were previously prescribed for the resident; and, were intended to be included in resident #026's plan of care on admission to the home.

DOC #124, indicated to Inspector #655 that resident #026 did develop the above-described medical complication.

The licensee failed to ensure that drugs were administered to resident #026 over a period of five weeks in accordance with the directions for use specified by the prescriber as a result of an incomplete medication reconciliation process for resident #026 at the time of the resident's admission.

>Resident #032:

The licensee failed to ensure that drugs were administered to resident #032 in accordance with the directions for use specified by the prescriber.

According a medication incident report, RPN #120 found, while conducting a count of controlled substances on a specified date and time that a dose of a controlled

substance belonging to resident #032 was still in the medication package. According to the incident report, RPN #120 then administered the dose of the controlled substance to resident #032. In the same incident report, it is indicated that RPN #120 accidentally gave a co-resident's dose of the controlled substance to resident #032.

During an interview, RPN #120 recalled the same medication incident involving resident #032. According to RPN #120, they gave resident #032 a dose of the controlled substance on a specified date and time; but, had accidentally taken that medication from co-resident #035's supply. According to RPN #120, both residents (resident #032 and resident #035) had their own supply of the medication, in the same dosage. RPN #120 further explained to Inspector #655 that approximately two hours later on the same day, they had conducted a count of controlled substances. RPN #120 indicated to Inspector #655 that at the time of the count, they found that a dose of the controlled substance belonging to resident #032 was still in the package assigned to resident #032. RPN #120 indicated to Inspector #655 that at the time, they gave resident #032 the dose from the resident's own supply, unaware at the time that they had already given resident #032 the dose from resident #035's supply. Consequently, according to RPN #120, resident #032 received two separate doses of the controlled substance (double the prescribed dose) during the evening shift of a specified date.

Over the course of the inspection, DOC #124 confirmed that resident #032 had received an extra dose of the controlled substance (or double the prescribed dose) on a specified date. There were no known adverse affects to the resident.

The licensee failed to ensure that drugs were administered to resident #032 in accordance with the directions for use specified by the prescriber when resident #032 received two doses of a controlled substance instead of one during the evening shift of a specified date.

>Resident #036:

The licensee failed to ensure that drugs were administered to resident #036 in accordance with the directions for use specified by the prescriber.

The incident involving resident #036 was initially reported to Inspector #655 by a pharmacy representative. According to the pharmacy representative, a drug had been taken from the emergency box and administered to resident #036 on a specific

date; but, it was the wrong drug.

DOC #124 provided Inspector #655 with a copy of the "Medication Incident Report" related to the above-described incident that was reported to the inspector by a pharmacy representative. According to the medication incident report, the following order had been written for resident #036: a specified medication in a specific dosage, to be administered stat (immediately); and then, the same medication (in a specified dose) daily for a specified number of days. In the same incident report, it is stated that in response to the above-noted order, a different medication had been given in error "yesterday and today".

Attached to the medication incident report was a copy of a progress note entered by RPN #125. According to the progress note, RPN #125 was approached by a family member of resident #036 on the day of the incident, at which time the family member expressed concern related to worsening symptoms experienced by resident #036. According to the progress note, the family member of resident #036 reported concern that the above- noted "stat ordered yesterday is not working". In the same note, resident #036 was described as exhibiting specific symptoms. The on-call physician was notified and new orders were received for another specified dose of the specified medication, to be administered immediately; and a different dose of the same medication to be administered in the morning; and then, the same medication to be administered in a different dose once a day for three days. In the progress note it states: "stat order administered" at a specified time, and then four hours later, "noticed that error occurred and writer called on call" again.

Over the course of the inspection, DOC #124 and Director of Resident Services #113 indicated to Inspector #655 that resident #036 received one dose of the wrong medication at the time of the initial, immediate order.

The licensee failed to ensure that drugs were administered to resident #036 in accordance with the directions for use specified by the prescriber.

>Resident #037:

The licensee failed to ensure that drugs were administered to resident #037 in accordance with the directions for use specified by the prescriber.

A medication incident involving resident #037 was initially reported to Inspector #655

by a pharmacy representative. The incident was initially discovered on a specified date; and was subsequently rediscovered just over a month later.

Over the course of the inspection, Assistant Pharmacy Manager #126 indicated to Inspector #655 that Consultant Pharmacist #127 discovered a transcription error during a medication reconciliation audit that was performed on a specified date, for resident #037. According to Assistant Pharmacy Manager #126, the error was discovered on the specified date; but had occurred 11 weeks earlier, when resident #037 was admitted to the home. Assistant Pharmacy Manager #126 indicated to Inspector #655 that when the error was discovered, it was reported to the Director of Resident Services (#113) who investigated the incident. Assistant Pharmacy Manager #126 indicated that as a result of the investigation, the pharmacy was informed that the admission order for a specified medication had not been processed by pharmacy, in error (that the incident was of a pharmacy origin). According to the pharmacy service provider representative, however, the MEDREC form that was prepared and faxed to the pharmacy on the day of the resident's admission to the home did not include an order for the specified medication. At the same time, Assistant Pharmacy Manager #126 indicated to Inspector #655 that the MEDREC form must have been amended after it was faxed to the pharmacy; though pharmacy did not receive a copy of the amended version.

During the inspection, Inspector #655 reviewed an admission medication source list titled "Medication Record", provided to the inspector by Director of Resident Services #113. Among the medications listed was the above specified medication. Inspector #655 reviewed the MEDREC form completed for resident #037, prepared by RN #107 on the day of the resident's admission to the home, and was unable to find any documentation on the form related to the specified medication.

During an interview, Director of Resident Services #113 confirmed that at the time of resident #037's admission to the home, the specified medication was omitted during the medication reconciliation process in error. At the time of the interview, Director of Resident Services #113 indicated to Inspector #655 that resident #037 did not receive the specified medication between a specified period of just over six weeks, after which time the error was found by Pharmacist Consultant #127.

Inspector #655 reviewed a document titled "MedsCheck LTC – Medication Regimen Review Pharmacist Recommendation Form", completed by Consultant Pharmacist #127 on a specified date, just over six weeks after resident #037's admission to the

home. On the form, it was indicated that a prescription for a specified medication (found on an admission medication list source) was not transcribed onto the MEDREC form when the resident was admitted to the home . On the same document, clarification was requested as to whether this was intentional or an error. On the document it is indicated that the potential error was reviewed with an RPN; and, a hand written note on the bottom of the form indicated that the specified medication was to be restarted.

Inspector #655 reviewed the physician's orders in resident #037's health care record and found only one order related to the specified medication. The order was dated just over a month later than the date at which the error was initially discovered. In addition, in a note written by the physician around the same time in the multidisciplinary progress notes, it was also indicated that the specified medication was to be restarted at that time as the resident was known to have a specific medical condition.

Inspector #655 reviewed the Medication Administration Records (MARs) belonging to resident #037 for a period of four months. The specified medication was not listed on any of the MARs prior to a specified date over 11 weeks after the resident's admission (and five weeks after the error was initially discovered). That is, there was no indication that resident #037 had been given the specified medication at any time over a period of over 11 weeks. On review of the resident's health care record, Inspector #655 noted that resident #037 was known to have a specific medical condition associated with the use of the specified medication which had been omitted.

Over the course of the inspection, DOC #124 indicated to Inspector #655 that all medications that are identified on the medication list sources at the time of a resident's admission to the home are medications which had been prescribed by a physician and are expected to be transcribed onto the MEDREC so that the need to continue or discontinue the given medication may be assessed by the attending physician in the home.

The licensee failed to ensure that a drug was administered to resident #037 in accordance with the directions for use specified by the prescriber over a period of over 11 weeks, as the result of a medication reconciliation process error at the time of the resident's admission.

The severity of this issue was determined to be a level 3 as there was actual harm to a resident as a result of a medication incident. The scope of the issue was a level 3 (widespread) as at least one medication was not administered in accordance with a prescribers directions in five out of six incidents that were reviewed during the inspection. The home had a level 4 compliance history, where continued non-compliance was identified with the original area of non-compliance:

- a written notification (WN) and Voluntary Plan of Correction (VPC) was issued under O. Reg. 79/10, s. 131 (2) on May 23, 2017 (Resident Quality Inspection #2017_617148_0015),
- a written notification (WN) and Voluntary Plan of Correction (VPC) was issued under O. Reg. 79/10, s. 131 (2) on Mar 23, 2017 (Complaint Inspection #2017_619550_0009); and,
- a written notification (WN) and Voluntary Plan of Correction (VPC) was issued under O. Reg. 79/10, s. 131 (2) on Mar 27, 2017 (Complaint Inspection # 2017_619550_0010).

As such, a compliance order will be issued. [s. 131. (2)] (655)

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

Nov 07, 2018(A1)

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 135 (2).

Specifically, the licensee shall:

1. Ensure that all medication incidents and adverse drug reactions are documented, reviewed, and analyzed by the Director of Care and appropriate designate (s), as applicable.

2. Ensure that the Director of Care and other personnel who will be assigned to the above noted tasks receive training on the best practices - or, if there are none, the prevailing practices, related to the review and analysis of medication incidents and adverse drug reactions.

3. Ensure that corrective action is taken as necessary as a result of the review and analysis referred to in step (1); and,

4. Ensure that a written record is kept of everything provided for in (1) (2) and (3).

The compliance due date for CO #003 is November 7, 2018.

Grounds / Motifs :

1. The licensee has failed to ensure that all medication incidents are documented, reviewed and analyzed.

Over the course of the inspection, Inspector #655 was made aware of two other

medication incidents (in addition to the incident involving resident #026) related to a transcription error. The first was related to resident #034, and did not reach the resident. The second involved resident #037, and it did reach the resident. There was no indication that either incident had been reviewed or analyzed when they were discovered.

>Resident #034:

Inspector #655 was provided with a "Medication Incident Report and Analysis Form" related to the first incident. According to the medication incident report, the incident occurred on a specified date. In the section "written description of incident", it was indicated that medication reconciliation was completed for resident #034 on a specified date, upon the resident's return to the home from the hospital. It is further stated that this was faxed to pharmacy; and that not all of the previous orders were removed from the resident's MAR.

On the same form, it is indicated that the incident was discovered by a nurse, and that the medications involved included medications of an oral (tablet/capsule) form, as well as medication in an injectable form. According to the medication incident report, the error did not reach the resident and therefore caused no harm. On the medication incident report, the error was classified as a "processing error". No causes or contributing factors were identified on the form (from a list of multiple options). In addition, there was no documentation found on the form under the section titled "Analysis of Incident"; or under the section titled "Corrective Action Plan". Under a statement which reads "Med incident has been documented, reviewed and analyzed by the multidisciplinary care team. Corrective action to prevent future incidents and harm to resident have been reviewed and documented", there is a space for the signatures of the Director of Care, the Medical Director or Physician, and the "Pharmacy Rep". There were no signatures found on the incident report.

During the inspection, Assistant Pharmacy Manager #126 indicated to Inspector #655 that the above-noted medication incident report had not been submitted to the pharmacy service provider for review. At the same time, Assistant Pharmacy Manager #126 indicated that the pharmacy was, however, notified via email that there was an incident. According to the Assistant Pharmacy Manager #126, the pharmacy was notified that an error occurred and that it occurred on a specified date, when the resident returned from hospital. Assistant Pharmacy Manager #126

indicated, however, that the pharmacy had no record of the resident being to hospital at that time; and that when they looked in the electronic census record, there was also no indication that the resident had been hospitalized at that time.

During an interview, Director of Resident Services #113 indicated to Inspector #655 that they were aware of an incident in which resident #034 was readmitted to the home from hospital with two different sets of hospital discharge orders. According to Director of Resident Services #113, the most recent set of orders from the hospital was used to complete the medication reconciliation process. At the same time, Director of Resident Services #113 indicated to Inspector #655 that the incident did not occur on the date specified on the medication incident report, and had likely occurred the following month. At the time of the interview, Director of Resident Services #113 was unable to elaborate, confirm the date of the incident or confirm whether the incident had reached the resident or not. Director of Resident Services #113 indicated that they would have to speak with DOC #124. According to Director of Resident Services #113, DOC #124 is the designate who would complete any follow-up related to medication incidents that occur on resident #034's resident home area; and regardless, all medication incidents reports are given to DOC #124 when complete.

During the inspection, DOC #124 indicated to Inspector #655 that they had not looked into the above-described incident, noting that there would be additional notes written on the medication incident report if they had. DOC #124 indicated that the pharmacy "must have" been notified; possibly verbally, about this incident.

During an interview, DOC #124 clarified that the above-described incident occurred on a specified date, not the date that was indicated on the medication incident report; and, that the incident was discovered ten days later. On the same day, DOC #124 explained to Inspector #655 that on the date the incident occurred, resident #034 returned to the home from hospital, at which time the medication reconciliation process was accurately completed and faxed to the pharmacy. DOC #124 further explained, however, that additional hospital discharge documents were sent to the home the following day. DOC #124 indicated that initially it was suspected that the medication reconciliation process may have been based on the incorrect hospital prescriptions; however, according to DOC #124 it was ultimately determined that there had been no transcription error, and that the resident had not been affected. According to DOC #124 the physician or nurse practitioner contacted the hospital at that time and confirmed that the first hospital discharge prescriptions (received when

the resident returned to the home on a specified date) were correct. At the time of the interview, DOC #124 indicated that for this reason, the incident was not pursued further.

Inspector #655 reviewed the health care record belonging to resident #034 and found that the medication reconciliation process was not completed in accordance with the licensee's policies, as described in WN # 1. Among the issues identified, it was found that not all pre-hospital medications were discontinued, and as a result two specific medications, which were also not listed on the MEDREC form, remained on the resident's MAR for a period of eight days following the resident's readmission to the home.

During the inspection, Inspector #655 reviewed the resident's MAR and the MEDREC form with DOC #124 who confirmed the same. DOC #124 was not aware of the transcription issues until Inspector #655 reviewed the MAR with them. DOC#124 indicated to Inspector #655 that they had not previously reviewed resident #034's MAR, though on the medication incident report related to this incident, it is stated that "not all previous orders were removed from the MAR".

There was no indication that the medication incident related to a transcription error during the medication reconciliation process when resident #034 was readmitted to the home from hospital on a specified date, had been reviewed or analyzed by DOC #124 or a designate, or by the pharmacy service provider.

>Resident #037:

The second incident involved resident #037, related to an error that initially occurred on a specified date, when the resident was admitted to the home. The incident was initially discovered on a specified date - approximately one month before the issue was corrected. Therefore, it resulted in a medication omission for a period of 11 weeks, as described in WN #2.

As described in WN #2, a document titled "MedsCheck LTC – Medication Regimen Review Pharmacist Recommendation Form", was reviewed by Inspector #655. The form was dated just over six weeks after the resident's admission to the home. On the form it was indicated that a prescription for a specified medication (found on an admission medication list source) was not transcribed onto the MEDREC form when the resident was admitted to the home. On the same document, clarification was

requested as to whether this was intentional or an error. On the document it is indicated that the potential error was reviewed with an RPN; and, a hand written note on the bottom of the form indicated that the specified medication was to be restarted.

There was no indication that, at that time (when the error was initially discovered), a medication incident report had been completed. In addition, there was no record to indicate that the incident had been reviewed or analyzed any further by the DOC or designate. In resident #037's MAR, there was also no indication that the medication had actually been restarted when the incident was first discovered.

According to Assistant Pharmacy Manager #126, Pharmacist Consultant #127 identified the same error during a medication reconciliation audit that took place just over a month after it was initially discovered. As described in WN #2, Assistant Pharmacy Manager #126 indicated to Inspector #655 that Director of Services #113 was made aware of the discovery and had informed the pharmacy that the error was a processing error of a pharmacy origin. At the same time, Assistant Pharmacy Manager #126 indicated to Inspector #655, however, that the original MEDREC form that was provided to the pharmacy when the resident was admitted to the home, did not include the specified medication. According to Assistant Pharmacy Manager #126, the incident was a transcription error of nursing origin. Assistant Pharmacy Manager #126 indicated to Inspector #655 that it is not within their role to analyze incidents of a nursing origin.

During an interview, Director of Resident Services #113 was aware that an incident had occurred involving resident #037, but could not recall any details. At that time, Director of Resident Services #113 indicated to Inspector #655 that they had not received or completed a medication incident report related to the incident themselves; and would have to look into it further in order to determine what had occurred.

On the same day, Inspector #655 was provided with a medication incident report that was dated one day after the error was discovered for a second time. The medication incident report had been completed by Assistant Pharmacy Manager #126. There was no indication that the incident had been reviewed or analyzed by the DOC or designate prior to the inspection.

Over the course of the inspection, it was confirmed that the incident was a

transcription error of a nursing origin which resulted in the omission of a specified medication for a period of over 11 weeks (see WN #2). Prior to the inspection, neither DOC #124 nor Director of Resident Services #113 had been aware that the omission of the specified medication for resident #037 had continued after it was first discovered.

The licensee failed to ensure that all medication incidents were documented, reviewed, and analyzed.

The severity of the issues identified under O. Reg. 79/10, s. 135, was determined to be a level 2 as there was potential for actual harm to residents as a results of the above-described findings. The scope of the issue was a level 3, as the above-described findings under s. 135 were related to all six of the medication incidents that were reviewed during the inspection. The home had a level 3 compliance history, with one or more related non-compliance in the last three years: a written notification (WN) was issued under O. Reg. 79/10, s. 135 (1) on May 23, 2018, (Resident Quality Inspection #2017_617148_0015). As such, a compliance order (CO) will be issued. [s. 135. (2)] (655)

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

Nov 07, 2018

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (3) Every licensee shall ensure that,

(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions;

(b) any changes and improvements identified in the review are implemented; and

(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/19, s. 135 (3).

Specifically, the licensee shall:

1. Revise the existing process, or develop and implement a new process, to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review.

2. Ensure that that this quarterly review of all medication incidents and adverse drug reactions includes a review of the reports of the medication incidents and adverse drug reactions by an interdisciplinary team as required under O. Reg. 79/10, s. 115 (1) and (3) (b).

3. Ensure that the above-described quarterly review of all medication incidents and adverse drug reactions is performed for the purpose of reducing and preventing medication incidents and adverse drug reactions, in accordance with best practices – or, if there are none, in accordance with prevailing practices.

4. Ensure that any changes or improvements identified as a result of the quarterly review of all medication incidents and adverse drug reactions are implemented; and,

5. Ensure that a written record is kept of everything provided for in steps (1), (2), (3), and (4).

The compliance due date for CO #004 is November 7, 2018.

Grounds / Motifs :

1. The licensee has failed to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

In accordance with sections 115 (1) and (3) (b) of Ontario Regulation 79/10, the quarterly evaluation of the medication management system must include a review of

the reports of any medication incidents and adverse drug reactions referred to in sections 135 (2) and (3) by an interdisciplinary team.

In the licensee's policy titled "Medication Management System Evaluation" (Policy Number: LTC-NAM-F-10.10), effective January, 2015, the same requirements are outlined.

Initially, during the inspection, DOC #124 was unable to speak to any processes in place for the quarterly review of all medication incidents. At the same time, DOC #124 indicated to Inspector #655 that each medication incident is reviewed at the time the incident is reported; and then, DOC #124 indicated that they will go over all medication incidents once every six months, approximately. DOC #124 indicated to Inspector #655 that there had been no medication incidents in the home in 2018 until a specified month. At the same time, DOC #124 was unable to confirm when the last review of all medication incidents would have taken place.

Later, DOC #124 indicated to Inspector #655 that the "Resident Services Department/Nursing Department Team" (the nursing department team) discusses and reviews medication incidents, if any have occurred in the home, when they meet. According to DOC #124 the nursing department team met on March 14, 2018; with the previous most recent meeting being held in December, 2017.

Over the course of the inspection, Director of Resident Services #113 provided Inspector #655 with a copy of the nursing department team minutes for the months of January, 2017, and October, 2017. Director of Resident Services #113 indicated to Inspector #655 that they had provided minutes for these months because these were the meetings at which medication issues were discussed.

The meeting minutes dated October 25, 2017, were reviewed by Inspector #655. There was no indication that any members of the interdisciplinary team were present at this meeting. In the meeting minutes there is a record of a discussion that took place related to the "narcotic destruction box", and regarding the "pre-pouring" and crushing of medications. However, there was no reference to any specific medication incidents that had occurred in the home or medication incident reports.

During an interview, Director of Resident Services #113 confirmed that only registered nursing staff attend the nursing department team meetings. At the same time, Director of Resident Services #113 confirmed that at the nursing department

meetings, the staff are made aware that there was an incident, and they are reminded about certain practices. Director of Resident Services #113 indicated to Inspector #655 that there is no review of the medication incident reports at these meetings.

During an interview, Consultant Pharmacist #127 indicated to Inspector #655 that they attend the Service Delivery Committee meetings at the home; but did not speak to a process in place for the review of medication incidents. At the same time, Consultant Pharmacist #127 indicated to Inspector #655 that they could not confirm that they had been notified of medication incidents which were of a nursing origin.

During an interview, Assistant Pharmacy Manager #126 indicated to Inspector #655 that quarterly evaluations of the medication management system are completed by Consultant Pharmacist #127; and presented at Professional Advisory Committee meetings (or, Service Delivery Committee meetings in this home). Assistant Pharmacy Manager #126 indicated to Inspector #655 that their own role was to review medication incident reports and enter data into excel. Assistant Pharmacy Manager #126 indicated that monthly and quarterly reports are subsequently created. According to Assistant Pharmacy Manager #126, the reports are to include medication incidents of both pharmacy and nursing origins. At the same time, Assistant Pharmacy Manager #126 indicated that not all medication reports are submitted to the pharmacy; and that only data related to incidents that are reported to the pharmacy are captured in the reports. Over the course of the inspection, DOC #124 also indicated to Inspector #655 that not all medication incidents are reported to the pharmacy service provider.

Inspector #655 was provided with a copy of the Service Delivery Committee meeting minutes dated September 26, 2017. Under a section titled "Medication incidents" it is indicated that there was one pharmacy incident in the second quarter of 2017, and 12 non-pharmacy incidents (omissions all occurring on the same day, during the same medication pass by one staff member) in the second quarter of 2017. There was no other documentation in the meeting minutes related to the review of reports of medication incidents in order to reduce and prevent medication incidents and adverse drug reactions.

During an interview, Director of Resident Services #113 indicated to Inspector #655 that when there are medication errors, the incident will be reviewed at either the Service Delivery Committee meeting, or the Nursing Executive Committee meeting.

According to Director of Resident Services #113, the Service Delivery Committee is interdisciplinary and includes among the members, a pharmacy representative and physician; whereas the Nursing Executive Committee meeting involves only the nursing managers. According to Director of Resident Services #113, the Service Delivery Committee meets on a quarterly basis. Director of Resident Services #113 indicated to Inspector #655 that they normally attend the Service Delivery Committee meetings, as well as DOC #124. At the same time, Director of Resident Services #113 indicated to Inspector #655 that they did not believe medication incidents were regularly reviewed at the Service Delivery Committee meetings, unless it was a major incident (such as the incident that occurred involving resident #026, as described in previous findings). Director of Resident Services #113 indicated to Inspector #655 that they may discuss the incidence of medication incidents without reviewing the details of the incident. Director of Resident Services #113 indicated to Inspector #655 that when information related to medication incidents is provided, it is provided by Consultant Pharmacist #127.

As a result of the inspection, Inspector #655 found that the incidence of medication incidents occurring in the home is discussed on a quarterly basis at Service Delivery Committee Meetings. However, there is no process in place whereby the reports of medication incidents are reviewed quarterly. In addition, the information reviewed at Service Delivery Committee meetings is based on the information that is provided to the pharmacy service provider using medication incident reports. As not all medication incidents are reported to the pharmacy service provider, not all medication incidents are considered in the quarterly review process.

There was no indication that a process was in place to ensure that the reports of all medication incidents were reviewed by an interdisciplinary team on a quarterly basis in order to reduce and prevent medication incidents and adverse drug reactions.

The licensee failed to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

The severity of the issues identified under O. Reg. 79/10, s. 135, was determined to be a level 2 as there was potential for actual harm to residents as a results of the above-described findings. The scope of the issue was a level 3, as the above-described findings under s. 135 were related to all six of the medication incidents that

were reviewed during the inspection. The home had a level 3 compliance history, with one or more related non-compliance in the last three years: a written notification (WN) was issued under O. Reg. 79/10, s. 135 (1) on May 23, 2018, (Resident Quality Inspection #2017_617148_0015). As such, a compliance order (CO) will be issued. [s. 135. (3)] (655)

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

Nov 07, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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 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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 20 day of September 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by MICHELLE EDWARDS - (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 : Ottawa