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 sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 11, 2019	2018_597655_0019 (A1)	025939-18, 026362-18, 026363-18, 026364-18	Follow up

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

Amended by MICHELLE EDWARDS (655) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance Order (CO) #001 and #002, and the grounds upon which they are based, are being referred to the Director for further action by the Director. The order report has been updated to reflect that this additional action is being taken.

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

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

Original report signed by the inspector.

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Amended by MICHELLE EDWARDS (655) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): November 19, 20, 21, 22, 23, 27, 28, 29, and 30, 2018; and, December 3, 4, 5, and 18, 2018, on-site. The inspection was conducted off-site on the following dates: December 19, 20, 21, 2018; and, January 10, and 11, 2019.

During this inspection, the following logs were inspected:

025939-18, 026362-18, 026363-18, and 026364-18, each a follow-up intake related to medication administration and/or the licensee's medication management system.

During the course of the inspection, the inspector(s) spoke with with residents and family members, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), a Consultant Pharmacist, the Director of Care (DOC), and Director of Resident Services (DRS), and the Administrator.

During the inspection, the inspector also reviewed resident health care records, internal medication incident reports, staff training records, policies and procedures and other relevant documents.

The following Inspection Protocols were used during this inspection:
Medication

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

5 WN(s)
3 VPC(s)
3 CO(s)
2 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. 131. (3)	CO #901	2018_597655_0019	655
O.Reg 79/10 s. 135. (2)	CO #003	2018_597655_0013	655
O.Reg 79/10 s. 135. (3)	CO #004	2018_597655_0013	655

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

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

Specifically failed to comply with the following:

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

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with compliance order (CO) #002, issued in

inspection report #2018_597655_0013, dated September 10, 2018, with a compliance date of November 7, 2018.

The licensee was ordered to:

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.or/globalassets/docs/prac/41007_medication.pdf ; and, "Medication Decision tool" at http://www.cno.org/en/learn-about-standards guidelines/educationaltools/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 licensee completed step #1 for the specific residents who were identified in CO #002. The licensee also completed step #2 and #3.

i. The licensee failed to complete step #1 for all readmitted residents (resident #006); and failed to ensure that drugs were administered to other residents (resident #008, #010 and #011) in accordance with the directions for use specified by the prescriber.

As such, the licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

>Resident #006:

Inspector #655 reviewed the health care record belonging to resident #006. According to the resident's health care record, resident #006 was hospitalized on

a specified date and subsequently returned to the home five days later, at which time the resident's pre-hospital and post-hospital medications were reconciled, as described in WN #2.

At the time of the resident's return to the long-term care home, several new orders were received, including an order for a specific medication to be given to the resident once a day.

As described in WN #2, Inspector #655 reviewed the eMAR for resident #006 for the month in which resident #006 returned to the home, and a paper MAR that was used for resident #006 in the days following their readmission to the long-term care home.

On review of the above-noted records, Inspector #655 was not able to find any documentation which would indicate that the above-referenced medication had been administered, or offered, to resident #006 on the day after they were readmitted to the long-term care home.

During an interview, RPN #112 recalled working on resident #006's resident home area, and being assigned to administer resident #006's medications. RPN #112 further indicated to Inspector #655 that because resident #006 had been readmitted to the home after pharmacy hours, their medications had not been provided by the pharmacy at the of the resident's readmission; and, had still not been provided the day after the resident returned to the home. RPN #112 indicated they were not sure that resident #006 had received their newly prescribed medication on the day after they returned to the long-term care home for this reason.

During an interview, RPN #100 recalled that although resident #006 had returned to the long-term care home from the hospital on a specified date, their medications had not been received from the pharmacy service provider until two days later and over 24 hours after the resident was readmitted to the home. According to the above-described MARs, it was then that resident #006 first received the prescribed above-referenced prescribed medication.

During an interview, DRS #106 indicated to Inspector #655 that when a resident returns to the home after-hours, or on a weekend, the pharmacy service provider does not always provide the resident's medications when needed.

The licensee was unable to demonstrate that resident #006 had received the above-described medication in accordance with the prescriber's directions on the day after they were readmitted to the long-term care home from the hospital.

As such, the licensee has failed to ensure that the drug was administered to resident #006 in accordance with the directions for use specified by the prescriber.

>Resident #008

During the inspection, Inspector #655 reviewed a medication incident report (MIR) related to an incident involving resident #008. The MIR described an omission error which occurred on a specified date. According to the MIR, RPN #107 found all of resident #008's morning medications to have been left at the resident's bedside, not taken by the resident.

Inspector #655 reviewed resident #008's eMAR for the month of the incident; and specifically, for the day of the above-noted medication incident. Resident #008's eMAR included directions related to ten different medications that were to be administered at the time of the incident. Some of the medications were to be administered more than once daily.

During an interview, RPN #107 recalled the medication incident involving resident #008 as described above. RPN #107 indicated to inspector #655 that the night nurse was to provide resident #008 with their morning medications before the resident left the home for a specified reason that day. However, according to RPN #107, that morning, the medications were found by a PSW staff member to have been left at the resident's bedside. RPN #107 indicated to Inspector #655 that in response, they called the resident's physician who advised them to administer the missed medications to the resident upon return to the home and to hold certain other medications.

The medications that were left at the resident's bed side had already been signed off in the eMAR as having been administered, although they were not taken by the resident at that time.

On review the above-described eMAR, Inspector #655 noted that entries made during a subsequent medication pass on the same day on the eMAR were indicative that two specific medications were not administered during the

subsequent medication pass as a result of the omission error described above. Resident #008 therefore received one of the specified medications three times that day (as opposed to four times), and another specific medication two times that day (as opposed to three times). In addition, the entry made for another one of the resident's medications (a medication which was to be administered only at a specific time that day) was indicative that the medication was not given on that day at all.

Resident #008 did not receive two specific medications at the frequency required by the original physicians order; nor did the resident receive a specific time-sensitive medication on the day of the incident.

As such, the licensee failed to ensure that resident #008's drugs were administered in accordance with the directions for use specified by the prescriber.

>Resident #010

During the inspection, Inspector #655 reviewed a medication incident report (MIR) related to an incident involving resident #010. The MIR described an administration error which occurred on a specified date. According to the MIR, RPN #113 administered an extra dose of a specific medication to resident #010, in error.

Inspector #655 reviewed the eMAR for resident #010 for the month in which the incident had occurred; and specifically, for the day of the above-described incident. According to the resident's eMAR, resident #010 was to be given a regular dose of the above noted medication at a specified frequency routinely; and, and a separate dose of the same medication at a specified frequency as needed, to a maximum of a specific cumulative amount from all sources each day. This is clarified in a document titled "Villa Marconi Medical Directives" to mean a maximum of a specific quantity within 24 hours from all sources.

According to the documentation on resident #010's eMAR, resident #010 was given all of their regular doses of the medication the day prior to the incident, and on the day of the incident; and, in addition, they were given additional doses in a specified amount at two specific times over the course of two days at a frequency which was not consistent with the prescriber's direction. As a result, resident #010 received over the maximum prescribed amount in a 24 hour period.

During an interview, RPN #113 recalled the above-described medication incident. RPN #113 indicated to Inspector #655 that they had received no information during a shift report regarding resident #010 having received an additional dose of the medication (a prn, or as needed dose) just prior to their shift starting. RPN #113 indicated to Inspector #655 that soon after their shift started, resident #010 reported a specific symptom. RPN #113 further indicated to Inspector #655 that, in response, they offered the resident a dose of the above-described medication. The resident agreed, and RPN #113 administered the medication. RPN #113 explained to Inspector #655 that they did not realize that the resident had already received a prn dose of the medication until they went to document in the eMAR. RPN #113 indicated that they should have checked the prn administration record prior to administering the the specific medication at that time; but, didn't.

The licensee failed to ensure that resident #010's drugs were administered in accordance with the directions for use specified by the prescriber when they were given an extra dose of a specified medication, in error.

>Resident #011

During the inspection, Inspector #655 reviewed a medication incident report (MIR) related to an incident involving resident #011. The MIR described an omission error which occurred on a specified date, but was discovered on the following day.

According to the MIR, resident #011's medications were found to be in the original medication package in the medication cart one day after they were scheduled to be administered. In the MIR it is indicated that although the medications had been found in the medication cart, they had been signed off in the resident's eMAR as having been administered by RPN #107. According to the MIR, four specific medications were involved.

During an interview, RPN #107 recalled the MIR involving resident #011 as it is described above. RPN #107 explained that resident #011 had some medications stored in bottles, and some in pouches. RPN #107 further indicated to Inspector #655 that on the day of the incident, a family member had spoken to them during the medication pass; and they did not realize that they had not prepared all of the medications for administration. RPN #107 indicated to Inspector #655 that on the day of the incident, they had signed all medications off as having been administered because, at the time, they thought they had been. RPN #107 further

indicated that the four medications noted above were later found by a colleague to still be in the medication cart.

On the specified date of the above-described incident, resident #011 did not receive four specific medications.

As such, the licensee failed to ensure that resident #011's drugs were administered in accordance with the directions for use specified by the prescriber.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to a resident as a result of the medication incidents. 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 three out of three of the medication incidents that were reviewed during the inspection; in addition to an instance where a newly admitted resident was initially unable to be provided with a required medication. 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) in a Resident Quality Inspection Report (#2017_617148_0015) dated May 23, 2017,
- a written notification (WN) and Voluntary Plan of Correction (VPC) was issued under O. Reg. 79/10, s. 131 (2) in a Complaint Inspection Report (#2017_619550_0009), dated March 23, 2017,
- a written notification (WN) and Voluntary Plan of Correction (VPC) was issued under O. Reg. 79/10, s. 131 (2) in a Complaint Inspection Report (# 2017_619550_0010) dated March 27, 2017; and,
- a written notification (WN), compliance order (CO), and Director Referral (DR) was issued under O. Reg. 79/10, s. 131 (2) in a Resident Quality Inspection Report (#2018_597655_0013) dated September 10, 2018.

As such, a compliance order will be re-issued under s. 131 (2) of O. Reg. 79/10.

ii. Other Medication Incidents Prior to the Compliance Due Date

In addition to the above-described findings, Inspector #655 was made aware of two other incidents related to medication administration over the course of the

inspection. The two other incidents involved resident #009, and resident #012, respectively.

>Resident #009

During the inspection, Inspector #655 was approached by an individual in the home who reported that registered nursing staff had administered a specific medication to resident #009 without measuring the dose. According to the individual, resident #009 received an amount of the specified medication which exceeded the prescribed dose.

Inspector #655 reviewed the health care record belonging to resident #009. According to the information in the resident's health care record, resident #009 had been prescribed a specific quantity of the specified medication, to be given once daily.

On review of the licensee's medication incident reports (MIRs), Inspector #655 found a MIR related to an incident involving resident #009. According to the MIR, the nurse on duty on a specified date was using "a cup without any measurements on it" to administer the medication to resident #009. The MIR report was prepared by DRS #106. On the form, it was stated that "when the amount of [the medication] was measured, there was [a specified amount] instead of [the intended amount] that would have been administered".

During the inspection, Inspector #655 spoke with a family member of resident #009. At that time, the family member of resident #009 indicated to Inspector #655 that registered nursing staff were now to prepare resident #009's medication using a different tool for measuring, in order to ensure that the correct amount was being prepared for administration. According to the family member, this was implemented in response to a previous incident in which the medication had not been accurately measured by registered nursing staff.

During an interview, DRS #106 recalled that a family member of resident #009 had reported that the registered nursing staff were administering the specified medication to resident #009 without measuring it. DRS #106 indicated that it was reported that all nurses were doing this, but specifically RPN #114. According to DRS #106 registered nursing staff had been using a cup that was intended to be used only for the pill crushing machine, with no markings for measuring. At the same time, DRS #106 confirmed that registered nursing staff were "eye-balling"

the amount of the specified medication to administer to resident #009, and that this had been confirmed on at least one occasion before it reached the resident.

The licensee failed to ensure that resident #009's drugs – specifically, the above-referenced medication, was administered in accordance with the directions for use specified by the prescriber, when the amount being administered to the resident had not been measured.

>Resident #012

During the inspection, Inspector #655 was approached by an individual in the home who reported an incident involving resident #012, in which the resident was not given a prescribed medication during an a specific shift by an agency staff member.

During the inspection, Inspector #655 spoke with a family member of resident #012 about the above-noted incident. The family member could not recall a specific date upon which the incident had occurred, but provided Inspector #655 with time-frame within which they believed the incident occurred. According to the family member of resident #012, they were told by an agency staff member on a specific shift that they did not have the keys required to access the medication that had been prescribed for resident #012. The family member further indicated to Inspector #655 that they reported the incident on the following day to RPN #104. At the same time, the family member of resident #012 indicated to Inspector #655 that they had also reported it themselves to the resident's physician, who advised them that they should report the concern because of the potential that a missed dose of the specified medication could have an impact on the resident. According to the family member of resident #012, the resident had a specific health condition at the time.

During the inspection, Inspector #655 was unable to locate a MIR that was consistent with the above described incident.

Inspector #655 reviewed the health care record belonging to resident #012. On review of the resident's health care record, Inspector #655 located a two physicians' orders for the specified medication, within the time frame provided by the family member.

On review of resident #012's eMARs, Inspector #655 found an entry dated a

specific day within the above-described time frame, for the specified medication which was indicative that the drug was not administered to the resident during the specific shift that day. There was no indication on the eMAR as to which specific staff member had made the entry on that day. Instead, it indicated that the medication was not administered and that this entry had been made by the resident's home area (the resident's home area name was entered instead of a staff member's name).
According to the scheduling clerk, RPN #104 (the same RPN to whom the family member recalled reporting the incident to) was working on resident #012's home area on the day following the above-noted entry on the eMAR.

During an interview, RPN #104 confirmed that the information that was entered in the above-described eMAR entry was indicative that an agency staff member had made the entry that shift. During the interview, RPN #104 reviewed resident #012's health care record with Inspector #655 including the above-described physician's orders. At the same time, RPN #104 recalled that after the first order, the physician then extended the course of treatment so that the resident was to receive the same medication until a specified date, approximately four days after the incident occurred. RPN #104 further indicated to Inspector #655 that they recalled that a family member had reported an issue with the medication not having been administered to the resident during a specific shift by an agency staff member, but was unable to elaborate.

Neither DOC #103 nor DRS #106 could speak to an incident involving resident #012 in which the resident had missed a dose of a prescribed medication.

The licensee failed to ensure that resident #012's drugs were administered in accordance with the prescriber's direction when an agency staff member failed to administer a specific dose of a specified medication.

The medication incidents involving resident #009 and resident #012 occurred prior to the compliance due date of November 7, 2018, and therefore the findings related to these incidents serve as additional evidence for CO #002, issued in report #2018_597655_0013, on September 10, 2018. [s. 131. (2)]

2. The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse, or a registered practical nurse.

i. During the inspection, Inspector #655 observed a medication pass. Specifically, Inspector #655 observed RPN #104 administer medications to resident #009.

RPN #104 was observed to prepare several oral medications for resident #009. Several medications were poured into medication cups. One of the medications had not been prepared by the RPN at that time as prescribed in the physician's order. RPN #104 then provided the medication cups to resident #009's family member, who then took the medications down a hallway out of the line of sight of both the Inspector and the RPN. After giving the medications to the family member, RPN #104 was observed by Inspector #655 to document in the resident's Medication Administration Record (MAR) that the medications were "not administered." RPN #104 was observed to enter an additional note indicating that the medication had been given to the resident's family member for administration. There was no discussion between RPN #104 and resident #009's family member related to any specified direction for the medication administration.

According to the MAR, resident #009 was to receive a specific quantity of one of the medications, by mouth once daily. The MAR also included specific directions for the preparation of this medication. Two days after the above-described observations, the documentation on resident #009's MAR was still indicative that resident #009's medications had not been administered.

During the inspection, Inspector #655 reviewed the health care record belonging to resident #009. At the time of the review, Inspector #655 found no written record outlining the plan of care related to resident #009's family member administering medications to the resident. There was no physician's order or any other provisions included in the resident's health care record.

During interviews, resident #009's family member indicated to Inspector #655 that they typically administer resident #009's medications to the resident after the nurse has prepared them, including the above-described medications which was to be prepared in accordance with specific directions. At the same time, resident #009's family member indicated to Inspector #665 that they had never been given any particular directions related to medication administration; and specifically, had not been informed of the specific directions related to this particular medication. According to resident #009's family member, there had been a history of nursing staff administering one of the medications to resident #009 without measuring it, resulting in amounts being administered to the resident which exceeded the

prescribed dose. The family member further indicated to Inspector #655 that they prefer to administer the medications in order to "catch errors." Resident #009's family member described re-checking the amount of a specified medication provided to them for administration to the resident by the nursing staff. Resident #009's family member indicated to Inspector #655 that when the dose is given to them by the nursing staff, they transfer the dose into a different cup to re-measure it. Resident #009's family member indicated that they then identify the correct amount, and "waste the rest" by pouring the excess drug out. At the same time, resident #009's family member indicated to Inspector #655 that there had been "no monitoring" by nursing staff to ensure that resident #009's medications had been administered by the family member after they were dispensed by the nurse.

During an interview, Consultant Pharmacist #105 indicated to Inspector #655 that the above-described medication is considered to be a high-risk medication.

In a policy titled "Medication Risk Management: High-Alert Medication Quick Facts" (Policy #8.12.0), revised July, 2014, it was indicated that the medication was a "high-alert" medication, meaning that it bears "a heightened risk of causing significant patient harm when they are used in error". The policy included information related to dosing and administration of the medication, as well as signs and symptoms to be monitored related to its use.

During an interview, DOC #103 indicated to Inspector #655 that the practice of having family members administer medications to residents is not consistent with the licensee's policy. At the same time, DOC #103 indicated that there were family members of residents' who resided on a particular unit in the home who had requested that they be the ones to administer medications to particular residents. During the same interview, DOC #103 indicated that where a family member has administered medications to a resident, the medications were to be signed off in the resident's MAR as having been administered only after they were administered. According to DOC #103, it remains the nurses' responsibility to confirm that the medication had in fact been administered whenever it is given by a family member. DOC #103 indicated that there was no requirement to have a physician's order for administration of a medication by family.

Two days after the initial observation (described above), the family member of resident #009 approached Inspector #655 in an area of the home which was not resident #009's home area. The family member reported to Inspector #655 that since the time of the above-described observation, they had been approached by

someone in the home, at which time they were notified that there would be a physician's order implemented which would outline provisions for their involvement in the administration of medications to resident #009. On the same day, the family member indicated to Inspector #655, they had been given the prepared medication to administer to the resident that day, but had not yet administered it.

Director of Resident Services (DRS) #106 indicated to Inspector #655 that nurses' are not expected to document that medications were administered to a resident on the resident's MAR when they were given to the resident by a family member because it cannot be documented this way "unless you have seen it yourself." According to DRS #106, a note would be made indicating that the medications were given to a family member for administration in the "medication notes." DRS #106 did not speak to the nurses' role in monitoring medication administration when a medication is given to a resident by a family member; and instead indicated to Inspector #655 that the expectation is that the family member would report back to the nurse if a medication had not been given.

Resident #009's medications (including a high-risk medication) were administered by a family member while the resident was in the long-term care home, without direction or monitoring by registered nursing staff.

In addition to the above described findings, over the course of the inspection, Inspector #655 found that resident #012's medication had also been administered by one of the resident's family members.

As such, the licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse, or a registered practical nurse.

ii. During the inspection, Inspector #655 observed a morning medication pass. Specifically, Inspector #655 observed RPN #100 administer medications to resident #003.

At the time of the observation, RPN #100 indicated to Inspector #655 that, sometimes, they ask another staff member to administer the medications to resident #003 after they are prepared because the resident is, at times, slow to ingest them. During an interview on the same day, RPN #100 indicated to Inspector #655 that some days, the resident takes "so long" to ingest the

medications, that they advise a PSW to administer the medications to resident #003 while they feed the resident. RPN #100 stated during the interview, that when the resident is slow to ingest the medications, they "can't be standing there" for the duration of the medication pass for resident #003.

During the inspection, PSW #101 asked Inspector #655 if PSWs were allowed to administer medications to resident's in the home. During the same interview, PSW #101 indicated to inspector #655 that the policy in the long-term care home related to a PSW's involvement in medication administration was "confusing" and "contradictory." When PSW #101 was asked if they had ever been asked to give a resident medications, the PSW indicated that "it depends." PSW #101 declined to elaborate.

During an interview, PSW #102 indicated to Inspector #655 that they are "sometimes" asked to give residents' their medications. PSW #102 indicated to Inspector #655 that if a resident has initially refused the medication, they may be asked; and, that when a medication is being administered to a resident in pudding or applesauce, they might be the staff assigned to spoon the medication to the resident.

During an interview, DOC #103 indicated to Inspector #655 that PSWs may be involved in administering medications to several residents after the medication is prepared by the nurse for reasons of behaviours or nurses' not having time to wait until the resident has ingested the medications.

Over the course of the inspection, DOC #103 indicated to Inspector #655 that the practice of having PSWs administer oral medications to residents in the home was not consistent with the licensee's policies. DOC #103 indicated to Inspector #655 that PSWs working in the home were trained on the administration of topical medications; but, that they received no other training related to medication administration.

As a result of the above-described findings, CO #901 was issued under s. 131 (3) during this inspection. The licensee subsequently complied with CO #901. [s. 131. (3)]

Additional Required Actions:

CO # - 901 was served on the licensee. CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with compliance order (CO) #001, issued in inspection report #2018_597655_0013, dated September 10, 2018, with a compliance date of November 7, 2018.

The licensee was ordered to:

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 licensee completed steps #1, 2, and 4.

The licensee failed to complete step #3 with regards to the medication reconciliation policies.

As such, the licensee has failed to ensure that where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy or protocol, that policy or protocol is 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.

A) Medication Reconciliation

Specifically, the licensee failed to ensure that the following policies and protocols related to medication reconciliation were complied with, despite having completed steps #1, 2, and 4 of CO #001 described above:

- "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),
- "Medication Reconciliation- Long Term Care Homes" (Policy Number 2.7.1), revised December, 2016; and,
- The companion document titled "Revision to Medication Reconciliation Process" (the revision document) dated 2018.

Inspector #655 reviewed all three of the above-identified policies related to medication reconciliation in addition to the revision document. Over the course of the inspection, Inspector #655 also reviewed the medication reconciliation process with RPN #100, RPN #107, DOC #103, DRS #106, and Consultant Pharmacist #105.

According to the licensee's policies (including the above-described revision document), the medication reconciliation process includes the following steps:

- The nurse is to create a best possible medication history (BPMH) from all

possible sources (at least two sources), during which time the resident or the resident's family (or, substitute decision-maker) may 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, and 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 transcribe all medication and treatment orders onto the MEDREC form as they are worded on the applicable medication list 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.

- On the MEDREC form, the resident label must be clearly visible, and all sections of the form including: gender, diet, allergies, and diagnosis are to be completed; and, all pages are to be numbered.

- 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 it (the admitting nurse) in the space allotted (labeled "Prepared by").

- A second nurse will sign beside the name of the nurse who prepared the MEDREC form, indicating that the prepared form was double-checked.

- The Admitting Nurse, or the nurse who prepared the MEDREC form, is then to contact the physician.

- The physician assesses the nurse prepared medication profile as recorded on the MEDREC form (and any supporting documents as applicable when/if on-site); and then provides direction to "continue", "discontinue", or "hold" each listed

medication. This is to be documented on the MEDREC form first by checking the appropriate box "continue", discontinue", or "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 or new medication orders), are also to be documented in the appropriate section(s) on the form, as applicable. New orders are to be identified as such on the MEDREC form, with the medication list source in this case being "other". The nurse is also to draw a vertical line through all supplemental (blank or un-used) drug boxes on the MEDREC form.

- The Admitting nurse is to obtain consent before processing the orders, and must indicate that consent was obtained on the bottom of the MEDREC form.

- The MEDREC form and medication list sources are then to be faxed to the pharmacy. A copy of the fax report is to be kept with the MEDREC documents.

- The pharmacy service provider will only process the orders if the faxed MEDREC form is completed in full. If the MEDREC form that is received by the pharmacy service provider is incomplete, the pharmacy will contact the nurse and/or physician, as required.

- The admission or readmission orders that are outlined on the MEDREC form are entered into the electronic Medication Administration Record (eMAR) for the applicable resident, at which time, a third and then fourth nurse are to sign the applicable MEDREC form as proof of verification that all orders on the MEDREC form are also in the eMAR.

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. In addition, the revisions to the medication reconciliation policies require that the resident's attending physician, upon their next visit to the home, reviews the resident's medical history including medication list sources and then sign and date each once they are reviewed.

At the time of the inspection, the medication reconciliation process done for any resident was being followed up upon by the completion of an internal audit by DOC #103, DRS #106 or delegate; and a subsequent audit by the consultant pharmacist within 2 weeks of the medication reconciliation process having been

completed for a resident.

i) Inspector #655 reviewed the health care records including medication reconciliation forms and medication list sources for four residents (including resident #006 and resident #008) who were admitted or readmitted to the long-term care after the compliance due date of November 7, 2018. In addition, Inspector #655 reviewed the related internal and pharmacy audits that were completed with regards to the medication reconciliation process for the four residents. In two of the four cases reviewed, the information reviewed reflected an on-going lack of adherence with the licensee's medication reconciliation policies by staff.

>Resident #006

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 #006 was readmitted to the home on a specified date.

Inspector #655 reviewed the health care record belonging to resident #006.

According to the progress notes, resident #006 was temporarily discharged from the home on a specified date and subsequently returned to the home five days later. According to a note entered on the same date that the resident returned to the home by RN #108, medication reconciliation had been completed for resident #006 following their readmission to the home, and a voice mail had been left for the on-call physician. According to an entry made by the same nurse on the same day, the medication-reconciliation orders were confirmed by the physician. In the same note, it was indicated that the resident's discharge papers and reconciliation had been faxed to the pharmacy.

According to the progress notes, the medication reconciliation for resident #006 was checked with another nurse the following day.

That is, the accuracy of the information on the prepared MEDREC form was not verified by a second nurse before the orders were approved via a telephone order by a physician, contrary to the requirements outlined in the licensee's policies and revision document.

Inspector #655 reviewed the applicable records (recent medication list sources)

that were provided for resident #006 upon the resident's return to the home. Inspector #655 also reviewed the "Re-Admission Medication Reconciliation Order" (MEDREC) form which was initially pre-populated with the resident's pre-discharge medications and was observed to have been updated with additional medication orders following the residents return to the home. The form was prepared by RN #108 on the day that the resident returned to the home, according to the documentation on the form.

In comparing the two records, Inspector #655 found that, also contrary to the licensee's policies, not all orders had been transcribed onto the MEDREC form. For two specific medications, the MEDREC form included only the pre-discharge directions from the long-term care home, and did not include the directions provided on the recent medication list sources.

As such, the above-described discrepancies between pre and post discharge orders related to the two specific medications were not reconciled or resolved at the time of the resident's readmission to the home.

On review of the above-described MEDREC form, it was further noted by Inspector #655 that there was no indication of which medication list sources had been used to complete the medication-reconciliation process; and, that the first nurses' signature for the completed review was not entered until four days after the resident's readmission, with the second nurses' signature for the completed review not entered until nine days after the resident was readmitted to the home. The process, including the required checks for accuracy, were not completed within the required timeframe.

Inspector #655 reviewed an internal audit (a document titled "Medication Reconciliation Audit") that was related to the medication reconciliation process completed for resident #006 when they were readmitted to the home. On the audit form, it was indicated that the audit had been completed by DOC #103 the day after the MEDREC had been prepared, confirmed with the physician, and reportedly faxed to the pharmacy (according to the progress notes).

The results of the audit were indicative that the licensee's medication reconciliation policies had not been complied with in the following ways:

a) The prepared medication reconciliation form had not been signed by two different nurses,

b) The "reviewed and completed" medication reconciliation form had also not been signed by two different nurses,
c) There was no indication that the resident and/or the resident's substitute decision-maker (SDM) had been involved in the process of medication reconciliation,
d) Discrepancies were found related to the orders for two specific medications and,
e) The pharmacy had not received the medication reconciliation orders on the day that the resident returned to the home.

Additional notes made on the audit form indicated that certain orders needed to be clarified; and that the discrepancy related to one of the above-noted medications was related to the order start date. In an additional note, it was indicated that the on-call pharmacist needed to be called first for after-hours medication-reconciliations (resident #006's re-admission medication reconciliation took place after-hours). There was no mention of one of the other discrepancies which had been identified by the Inspector on review of the resident's records (see above) on the internal audit form.

During the inspection, Inspector #655 also reviewed the audit completed by Consultant Pharmacist #105 related to the medication reconciliation process that was done for resident #006 upon their readmission to the home. The results of the audit were indicative that the licensee's medication reconciliation policies had still not been complied with in the following ways:

a) The medication list sources used to create the best possible medication history were not identified on the MEDREC form,
b) The MEDREC orders were not signed and double-checked by nursing; and,
c) Not all orders had been transcribed onto the MEDREC form, resulting in an unclarified discrepancy.

In an additional note on the audit form, it was indicated that both orders – including the one that was identified in the recent medication list sources and the pre-discharge order should have been transcribed onto the MEDREC form so that the discrepancy could be resolved in consultation with the physician. According to the note, one order would then be discontinued, and the other continued.

On review of resident #006's health care record, Inspector #655 found records that were indicative that all orders had been clarified the day that the internal audit

had been completed by DOC #103 and one day following the resident's return to the long-term care home; with the exception of one order for the specific medication referred to in the audit conducted by the pharmacy service provider.

Inspector #655 reviewed the Medication Administration Record (MAR) for resident #006, for the month in which the resident had returned to the home, including the eMAR and a paper MAR that had been temporarily utilized for resident #006 following their admission to the home. On review of the MAR, Inspector #655 noted that the resident had not received the specific medication for which there was an unclarified discrepancy in prescriber directions at any time since they had returned to the home, and therefore there would have been no impact on the resident as a result of the failure to clarify the order during the medication-reconciliation process.

During the inspection, Inspector #655 spoke with registered nursing staff on resident #006's resident home area. The staff who were interviewed also found no indication in the resident's health care record that the above-described discrepancy in the specified medication order's had been clarified during the medication reconciliation process, or any time after. The staff indicated that they would leave a note to ensure the order was clarified by the physician.

During an interview, DRS #106 confirmed that the orders for the specified medication had not been clarified until "recently".

The licensee failed to ensure that the medication reconciliation process was completed in accordance with the licensee's policies when resident #006 was readmitted to the home.

>Resident #008

Inspector #655 reviewed the health care record belonging to resident #008.

In the resident's health care record, it was indicated that resident #008 was temporarily discharged from the home on a specified date, and subsequently returned to the home two days later.

Inspector #655 reviewed the MEDREC form which had been completed for resident #008 on the day they returned to the home. The MEDREC form used in this case did not include a pre-populated list of pre-discharge medications.

Inspector #655 also reviewed the medication list sources which, in this case, would have included the resident's pre-discharge eMAR as well as the recent medication list sources provided at the time of the resident's readmission to the home.

The MEDREC form was prepared by RN #110. According to the documentation on the form, the prepared MEDREC had been reviewed (or double-checked) by RPN #107 on the same day.

On review of the MEDREC form, Inspector #655 noted that two additional nurses had signed the MEDREC form, also on the day that the resident returned to the home, in the sections labeled "First Check By" and "Second Check by". That is, the MEDREC form was reviewed by a total of four nurses on the day that the resident returned to the home, according to the documentation on the form.

Despite the above-described checks having been completed, several medications that would have been listed on the resident's pre-discharge e-MAR were omitted from the MEDREC form:

- Several (approximately 15) individual pre-discharge orders related to medications that were part of the long-term care home's "Medical Directives" were not recorded on the MEDREC form when the resident returned to the home. It was instead indicated on the MEDREC form that "Medical Directives as per Villa Marconi LTC" were to be continued. However, this practice was contrary to the licensee's policies which required that each medication order be written exactly as it was indicated on the source document, including the medication name, strength, and dose, route of administration, frequency, and indication for use, if known at the time of admission. None of this information was documented on the MEDREC form for the 15 medications.
- Eight other pre-discharge medications were omitted; and,
- Three other non-pharmaceutical interventions were also missing from the MEDREC form.

In addition to the above, it was found that for two specific medications, there was a dose discrepancy between pre and post discharge directions. For both of these medications, the MEDREC form included only the directions from the recent medication list sources.

The day after the resident returned to the home, the above-described discrepancies involving two specific medications were resolved. In both cases, the physician ordered that the orders identified on the recent medication list sources were to be discontinued; and that the pre-discharge orders (per the resident's eMAR) were to be continued instead. In addition, orders were obtained to continue/clarify the directions related to the other medications that had initially been omitted on the MEDREC form when it was prepared.

On review of resident #008's health care record, including progress notes, it was found that resident #008 had been given a dose of each of the above-referred to medications in accordance with the recent medication list sources - before the orders (pre-discharge vs. readmission/post-discharge) had actually been clarified. However, all medications were clarified within 24 hours of the resident's admission, despite the transcription errors on the MEDREC form.

On review of the physician's orders, it was found that the orders for the other non-pharmaceutical interventions had been clarified two days after the resident was readmitted to the home.

Inspector #655 reviewed an internal audit (a document titled "Medication Reconciliation Audit") that was related to the medication reconciliation process completed for resident #008 when they were readmitted to the home. On the audit form, it was indicated that the audit had been completed by DRS #106. The results of the audit were indicative that the licensee's medication reconciliation policies had not been complied with in the following ways:

a) The medication reconciliation was not completed using the appropriate medication reconciliation form (in this case, the yellow MEDREC form which would have included a pre-populated list of the resident's pre-discharge medications if used),
b) Two or more medication list sources had not been used to create the BPMH (recent readmission documents were not compared to the pre-discharge MAR or other source),
c) Discontinued medication orders were not clearly crossed out; and,
d) Discrepancies or errors were found.

Additional notes on the audit form were indicative that because the main source for the reconciliation was the recent medication list sources provided on the resident's return to the hom, many medications were missed from the previous

MAR, and discrepancies were also missed. According to the note on the medication audit form completed by DRS #106, "many clarifications and additions were made on regular order sheets as missing items or discrepancies were identified. As of today [two days after the resident was readmitted], all orders have been clarified".

At the time of the inspection, there was no indication that the failure to comply with the licensee's medication reconciliation policies had otherwise reached the resident.

The incorrect MEDREC form (which did not include any pre-discharge medications) was used, and the resident's pre-discharge eMAR was not used as a second medication list source in order to create the best possible medication history when resident #008 returned to the home.

As such, the licensee failed to ensure that the medication reconciliation process was completed in accordance with the licensee's policies when resident #008 was readmitted to the home.

The above described findings present an on-going risk to residents related to a lack of adherence to the same policies related to medication reconciliation. As such, a compliance order (CO) will be re-issued.

B) Other Policies and Protocols Not Complied With

Over the course of the inspection, it was determined that other policies and protocols related to the medication management system had not been complied with.

> Documentation of Medication Administration

During the inspection, Inspector #655 reviewed the following policies related to medication administration and documentation:

- "Administering Routine Medications" (Policy Number 4.2), revised November, 2015,
- "Administering Routine Medications Using MED e-Care" (Policy Number 9.10), revised November, 2015,
- "Administering PRN Medications" (Policy Number 4.2), revised November, 2015;

and,
- "Non-Administered Medications" (Policy #4.5), revised July, 2014.

According to the above-noted policies, each individual medication is initialed as administered on the eMAR or MAR only upon administration of the medication.

Over the course of the inspection, DOC #103 further clarified that registered nursing staff were expected to document a medication as having been administered only after the medication was ingested by the resident.

In addition, according to the licensee's policies, when a medication is not administered, an entry must be made in accordance with the MAR legend to indicate the reason for not administering. Among the options are codes for: drug refused, hospitalization, or "other" (which would require a progress note).

i. During the inspection, Inspector #655 observed RPN #107 administer medications to resident #001. During the observation period, Inspector #655 observed RPN **#**107 to sign the resident's medications off on the resident's eMAR as having been administered as each one was poured into the medication cup, before the medications were given to the resident.

ii. During the inspection, Inspector #655 reviewed three medication incident reports related to medication incidents which had occurred after the compliance due date of November 7, 2018. In two out of the three medication incidents (the incidents involving resident #008 and resident #011, respectively), it was determined that the resident's medications had been signed off in the resident's eMAR as having been administered, although they had not been. Refer to WN #1 for additional information related to the medication incidents.

iii. During the inspection, Inspector #655 found multiple discrepancies in MAR documentation for resident #006. The MAR documentation for resident #006 was missing, and/or did not accurately reflect whether the resident received their medications in accordance with the plan of care, or not.

>Resident #006

Inspector #655 reviewed the health care record belonging to resident #006. According to the resident's health care record, resident #006 was temporarily discharged from the home on a specified date, and subsequently returned to the

home five days later, at which time the resident's pre-discharge and post-discharge (readmission) medications were reconciled, as previously described.

At the time of the resident's return to the home, new orders were identified through the medication reconciliation process.

On review of the MEDREC form which had been prepared and completed for resident #006, the new medication orders were identified as medication orders to be continued.

Inspector reviewed the eMAR for resident #006 for the month in which the resident had returned to the home; and specifically, for the period immediately following the resident's readmission to the home. The documentation on the eMAR for the two days following the resident's readmission was indicative that the medications were either not administered; or, were administered to resident #006 in doses that were not consistent with the new orders.

Over the course of the inspection, it was determined that a paper MAR in addition to the above described e-MAR may have been used in the days after resident #006 was readmitted to the home.

Inspector #655 located and reviewed the above-described paper MAR. On review of the paper MAR, Inspector #655 found no record that would indicate that five specific medications had been administered to resident #006 on the day after the resident was readmitted to the long-term care home. An entry made on the same day for a sixth medication read "N/A". For all of the other identified medications, there was no entry made at all.

During an interview, Inspector #655 reviewed the above-described entries which had been made in resident #006's eMAR and on resident #006's paper MAR on the days following the resident's readmission to the home with RPN #100. At the time of the interview, it was determined that RPN #112 had been working on the day after the resident was readmitted to the home, and may have made the entries related to medication administration for this resident on that particular day. However, at the same time, RPN #100 recalled administering medications to resident #006 two days after the resident had been readmitted. RPN #100 indicated to Inspector #655 that on that day (two days after the resident's readmission), they had received the appropriate medications from the pharmacy

and gave the medications at that time. RPN #100 demonstrated that they had signed the paper eMAR to indicate that they had administered certain medications in doses that were indicated in the post-discharge/readmission documents, and in the MEDREC admission orders. RPN #100 further clarified that the entries made in the eMAR on that day, which were inconsistent with the admission orders must have been made in error. According to RPN #100 resident #006 received their medications as prescribed on a specified date – two days after the resident was readmitted to the home.

Inspector #655 spoke with RPN #112 who was identified as having been assigned to administer medications to resident #006 on the day after the resident had been readmitted to the home.

During an interview, RPN #112 indicated to Inspector #655 that they recalled resident #006 had returned to the home on a specified date, and that the medication reconciliation process was "very confusing". RPN #112 further indicated to Inspector #655 that the when resident #006 returned to the home, the pharmacy had already closed; and therefore, the pharmacy was unable to provide any of the medications required for resident #006 on their return to the home. RPN #112 further recalled that they had not been working when resident #006 returned to the home, but that they were working the following day. According to RPN #112, they found at that time, that certain medications which had been discontinued while the resident was out of the home had remained in the resident's eMAR, and other (new) orders had not yet been added to the eMAR. RPN #112 further indicated that on that day, they did not know where the paper MAR was for resident #006, and for this reason, had documented the administration of resident #006's medications not on a paper MAR but on a "plain piece of paper". At the time of the interview, RPN #112 was unsure where this paper had gone. RPN #112 indicated to Inspector #655 that on this day, they did not receive medications from the pharmacy service provider, but they were able to administer certain medications in the correct doses (as per the post-discharge /MEDREC readmission order) by splitting the tablets that were available to them. RPN #112 further indicated to Inspector #655 that certain other medications were accessible in the home's "stock" (or emergency supply) and that the resident may have also had an existing supply of some medications. RPN #112 recalled that for this reason, they were able to administer certain medications as required. RPN #112 indicated, however, that they were not sure if resident #006 had received one specific, newly prescribed medication on their return to the home, noting this medication would not have been available in the "stock" supply kept in the home,

and the resident would not have had an existing supply in their medication pack.

Inspector #655 was unable to determine whether the resident received their medications as ordered on the fourth day after their readmission to the home. However, over the course of the inspection, it was determined that resident #006 had received all of their medications (except for one specific medication) in accordance with the plan of care on the second and third days following their readmission to the home. The administration of the medications on day after the readmission, was not documented on the eMAR or paper MAR as required by the licensee's policies; and the documentation on the MAR for the second day following readmission, did not accurately reflect what was provided to the resident that day.

As such, the licensee failed to ensure that their policies related to documentation of medication administration were complied with.

>Drug Destruction and Disposal

Over the course of the inspection, Inspector #655 reviewed the following policies related to the destruction and disposal of non-controlled medications, provided to Inspector #655 by ADOC #115:

- "Non-Administered Medications (Paper MAR)" (Policy Number 4.5), revised July, 2014; and,
- "Medication Disposal" (Policy Number 5.8), revised July, 2014.

According to the first policy, non-administered medications which have been documented as such in the MAR will not be administered at a later time as they are past their scheduled time for administration; and therefore, are to be disposed of in accordance with Policy #5.8.

According to the latter policy, medications for disposal are to be stored in a designated, secure, area of the home until the destruction and disposal can occur. Medications for disposal are to be destroyed at the home, by a team comprised of a registered staff member and another staff member, both of whom are to be appointed by the Director of Care. According to the policy, medications that are to be designated for disposal include those that were held, discontinued, or otherwise not used because a resident had been discharged.

i. During the inspection, Inspector #655 reviewed the health care record belonging to resident #009.

Inspector #655 reviewed resident #009's eMAR for a specified month. According to the documentation on the eMAR, resident #009's prescribed medications were not administered to the resident over a period of almost five days.

According to resident #009's health care record, resident #009 was transferred out of the home on a specified date and then returned to the home, almost five days later.

In a current care plan document, it was indicated that certain medications that had not been administered would be returned to the resident's substitute decision-maker for self-disposal, and that nursing staff were to safeguard non-administered medications. In a progress note entered by DOC #103 on a specified date, the same interventions were outlined.

During an interview, the family member of resident #009 confirmed that the resident had been out of the home for the period of almost five days. At the time of the interview, the family member of resident #009 recalled that when the resident returned to the home, they had inquired about the five days- worth of medications that had not been administered to the resident during the resident's absence. The family member indicated to Inspector #655 that initially, they had been advised by DOC #103 that the medications were to be disposed of. However, the family member indicated that ultimately several medications had been returned to them, including two specific drugs. The family member of resident #009 further explained that they had been given all of the resident's medications – specifically, the resident's "whole strip package" for at least some of the days that the resident had been in hospital, noting that other days were missing from the supply that was returned to them.

During an interview, RPN #104 indicated that they believed that some of resident #009's medications which had not been used during the resident's absence had been given to the resident's family member. According to RPN #104, resident #009 was temporarily discharged from the home on a specified date, and returned to the long-term care home almost five days later.

On the same day, RPN #104 and RPN #109 accompanied Inspector #655 to the medication room, and showed Inspector #655 a blue storage bin which, according

to the RPN's was a designated temporary storage area for medications (non-controlled) that were to be disposed of. At the same time, Inspector #655 was shown which medications belonging to resident #009 had been stored in the temporary disposal bin. On observation of the medications stored in the bin, a two-day supply of medications for resident #009 were found. There were no medications (specifically, two specific drugs) found in the storage bin for resident #009 for the remaining three days of the resident's absence from the home.

RPN #104 recalled that resident #009 had returned at a specific time on a specific date. RPN #104 further indicated to Inspector #655 that they worked on the following day, at which time they found that the non-administered medications belonging to resident #009, intended for use on the three remaining dates of the resident's absence, were still attached to the medication strip in the medication cart. RPN #104 recalled removing these medications from the medication cart at that time, and placing them in the storage bin in the medication room - the same bin described above, in which the medications in question could not be found.

During an interview, DRS #106 indicated to Inspector #655 that they were not aware that any medication had been returned to the family member of resident #009. At the same time, DRS #106 indicated to Inspector #655 that it is the licensee's practice to dispose of and destruct non-administered medications in the home.

Over the course of the inspection, DOC #103 indicated to Inspector #655 that they had returned only the certain supplements (as opposed to drugs) to resident #009's family member.

During the inspection, Inspector #655 spoke with a representative of the pharmacy service provider, who indicated that they had not yet been to the home to complete the process of destruction and disposal of non-controlled medications at the time; and therefore, could not speak to whether the above-described medications were in fact disposed of.

Following the on-site portion of the inspection, it was confirmed by an individual in the home that the above-noted medications in question were not found by themselves or by the pharmacy service provider who had later been on-site at the long-term care home to complete the disposal and destruction processes of the unused, non-controlled, medications.

Inspector #655 was unable to verify what happened to the above-listed medications as a result of the inspection, but did confirm that the medications were not being stored in the designated area of the home pending destruction and disposal, as required by the licensee's policies.

As such, the licensee has failed to ensure that the policy titled "Non-Administered Medications (Paper MAR)" (Policy Number 4.5), revised July, 2014; and the policy titled "Medication Disposal" (Policy Number 5.8), revised July, 2014, was complied with.

>Administration of Medications by Non-Registered Nursing Staff

Over the course of the inspection, DOC #103 indicated to Inspector #655 that the administration of medications by non-registered staff, including administration of medications by PSWs and by family members was not consistent with the licensee's policies.

During the inspection, it was found that family members of resident #009 and resident #012 had been administering medications to a resident. In addition, it was found that PSWs would administer medications to residents when required – for example, when a resident demonstrated behaviours, or a registered nurse did not have enough time to complete a medication pass for a particular resident. Refer to WN #1 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 2 as there was potential for actual harm to residents as a result of a failure to comply with medication policies. The home has a level 4 compliance history, where continued non-compliance was identified with the original area of non-compliance:

- A written notification (WN), Compliance Order (CO), and Director Referral (DR) was issued in a Resident Quality Inspection Report (#2018_597655_0013), dated September 10, 2018.

As such, a compliance order (CO) will be re-issued under s. 8 (1) b) of O. Reg. 79/10.

In addition, CO #901 was issued under O. Reg. 79/10, s. 131 (3) during the follow-up inspection (See WN #1, and refer to the "Orders of the Inspector"). [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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. . All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. . Any other areas provided for in the regulations. 2007, c. 8, s. 76.

(2). Findings/Faits saillants :

1. The licensee has failed to ensure that no person performed their responsibilities before receiving training on all policies that are relevant to the person's responsibilities.

Pursuant to s. 76 (1) of the LTCHA, 2007, every licensee of a long-term care home was required to ensure that all staff at the home received training as required by s. 76.

As per s. 74 (2) of the LTCHA, 2007, "agency staff" means staff who work at the long-term care home pursuant to a contract between the licensee and an employment agency or other third party.

As per s. 75 (3) of the LTCHA, 2007, a staff member who is agency staff, as that term is defined in subsection 74 (2), is considered to be hired when he or she first works at the home.

Specifically, the licensee failed to ensure that registered nurses who are agency staff were trained on the licensee's medication policies.

Over the course of the inspection, Inspector #655 reviewed educational content and attendance records maintained for a mandatory training session that was implemented in the home and delivered to all registered nursing staff in the home in response to CO #001 and CO #002 (see WN # 1 and WN # 2) which outlined a requirement to ensure that all registered nursing staff received training on medication administration and specified policies related to the medication management system.

On review of the above-described records, it was found that all members of the registered nursing staff who were employed directly by the licensee, received training as required by CO #001 and CO #002. However, there was no record of any agency staff member having received any of the training.

During an interview, DRS #106 provided Inspector #655 with a copy of two written letters, each of which had been provided to the licensee by the applicable agencies who had supplied registered nursing staff ("agency staff") to the home when needed. The letters were a written confirmation that registered agency staff had received training related to medications and medication administration, provided by the agency. Still, there was no indication that registered nurses who were agency staff had received any training on the licensee's own policies related to the medication management system.

Over the course of the inspection, DRS #106 indicated to Inspector #655 that they had created a first draft of review material related to the licensee's medication policies, to be provided to agency staff working in the home. According to DRS #106 the form was under development and had not yet been implemented at the time of the inspection. At the same time, DRS #106 described the usual orientation process for registered agency staff. According to DRS #106, orientation is done by shadowing regular registered nursing staff in the home. DRS #106 indicated to Inspector #655 that the "buddy-shift" included a review of medication passes, including the software being used in the home and resident care needs. DRS #106 indicated to Inspector #655 that policies in general were accessible to agency staff; however, there was otherwise no indication that agency staff had received any training on the licensee's policies related to the medication management system during orientation, or any other time.

The licensee has failed to ensure that no person (specifically registered nurses who were agency staff) performed their responsibilities before receiving training on policies related to the medication management system which were relevant to the person's responsibilities. [s. 76. (2) 10.]

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 no person mentioned in subsection (1) performs their responsibilities before receiving training on all Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 comply with the following requirement of the LTCHA, 2007: it is a condition of every licence that the licensee shall comply with every order made under this Act.

The following compliance order (CO #003) was issued under s. 135 (2) in Inspection Report #2018_597655_0013, dated September 10, 2018:

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 date was November 7, 2018.

The licensee completed step #'s 1, 3, and 4 in CO#003.

The licensee failed to complete step # 2.

Over the course of the inspection, it was established that medication incidents that had occurred in the home were to be reviewed and analyzed by DOC #103 or DRS #106.

According to DOC #103 and DRS #106, in order to comply with step #2 as described above, they attended the same mandatory training that was provided to all registered staff in the home related to medication incidents; and, they had reviewed and "signed-off" on the policy titled "Medication Management System Evaluation" (Policy #LTC-NAM-F-10.10), effective January, 2015, as part of their training. According to DOC #103 and DRS #106, the mandatory training that was provided to all registered nursing staff in the home was delivered by the pharmacy service provider. It was further indicated to Inspector #655 that DRS #103 had

later completed additional training by participating in a workshop delivered by the Institute for Safe Medication Practices (ISMP): "Medication Safety: Incident analysis and proactive risk assessment" on November 8 and November 9, 2018 – after the compliance due date.

Inspector #655 reviewed the above-noted policy which was found to include the signatures of the DOC and DRS. On review of the policy, Inspector #655 found that its contents was related to the requirements for a quarterly evaluation of the medication management system by an interdisciplinary team, which included a "review of reports of any medication incidents and adverse drug reactions". There was no further information in the policy related to medication incidents or medication incident reports. Specifically, there was no direction or information related to the individual review or analysis of each medication incident.

Inspector #655 reviewed the content of the mandatory education session that was provided to all registered nursing staff in the home, including DOC #103 and DRS #106. On review of the content provided, Inspector #655 found no information related to the review and analysis of medication incidents.

Over the course of the inspection, Consultant Pharmacist #105 confirmed that they had been involved in the delivery of the training that was provided to all registered nursing staff, including DOC #103 and DRS #106. At the same time, Consultant Pharmacist #105 indicated to Inspector #655 the they had not provided any training to the DOC or the DRS with regards to the processes of reviewing and analyzing medication incidents.

Over the course of the inspection, there was also no indication that DOC #103 had received the training at any time; and no indication that the training that was completed by DRS #106, delivered by the Institute for Safe Medication Practices (ISMP): "Medication Safety: Incident analysis and proactive risk assessment" on November 8 and November 9, 2018, had been incorporated into the review or analysis of individual medication incidents when three medication incidents were reviewed during the inspection.

The licensee failed to ensure that DOC #103 and DRS #106 received 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 before the compliance due date of November 7, 2018. [s. 101. (3)]

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 the licensee complies with every order made under this Act, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was 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 three MIRs related to medication incidents which had occurred after November 7, 2018. In one out of the three cases reviewed, there was no record of the immediate actions taken to assess and maintain the resident's health documented together with the medication incident.

The incident for which there was no record of the immediate actions taken to assess and maintain the resident's health was related to the incident involving resident #010, as described in WN #1.

As described in WN #1, resident #010 was given an extra dose of a specific medication in error on a specified date. As a result of the error, resident #010 received more than the maximum amount of the drug that was permitted, per prescribed direction, within a 24 hour period. During the inspection, RPN #113 confirmed the same. RPN #113 indicated to Inspector #655 that resident #010 was closely monitored after the incident for that reason.

Inspector #655 reviewed the MIR for the above-described incident and found no record of the immediate actions taken to assess and maintain resident #010's health when the incident occurred.

Inspector #655 reviewed the progress notes for resident #010 for the date of the incident. In an entry made by RPN #113, it was indicated that resident #010 had been given one tablet of the specified medication for a particular symptom; and in a subsequent entry by the same nurse, it indicated that resident #010 was sleeping comfortably. The note indicated that the resident would be monitored. However, there was no other documentation in the resident's progress notes related to the occurrence of the medication incident, and no other information related to the actions taken to assess and maintain the resident's health in response to the incident.

As such, the licensee has failed to ensure that the medication incident involving resident #010 had been documented, together with a record of the immediate actions taken to assess and maintain the resident's health. [s. 135. (1)]

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 every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, to be implemented voluntarily.

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

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by MICHELLE EDWARDS (655) - (A1)
Inspection No. / No de l'inspection :	2018_597655_0019 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	025939-18, 026362-18, 026363-18, 026364-18 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 11, 2019(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

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 : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 131 (3).

Specifically the licensee shall:

a) Immediately cease the practice of non-registered nursing staff and other persons administering drugs to residents in the home except as outlined in O. Reg. 79/10, s. 131, subsections (4), (4.1), (5), (6), and (7);

And,

b) Ensure that residents' substitute decision-makers remain involved in the care planning process related to medication administration.

Grounds / Motifs :

1. 2. The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse, or a registered practical nurse.

i. During the inspection, Inspector #655 observed a medication pass. Specifically, Inspector #655 observed RPN #104 administer medications to resident #009.

RPN #104 was observed to prepare several oral medications for resident #009. Several medications were poured into medication cups. One of the medications had not been prepared by the RPN at that time as prescribed in the physician's order.

RPN #104 then provided the medication cups to resident #009's family member, who then took the medications down a hallway out of the line of sight of both the Inspector and the RPN. After giving the medications to the family member, RPN #104 was observed by Inspector #655 to document in the resident's Medication Administration Record (MAR) that the medications were "not administered." RPN #104 was observed to enter an additional note indicating that the medication had been given to the resident's family member for administration. There was no discussion between RPN #104 and resident #009's family member related to any specified direction for the medication administration.

According to the MAR, resident #009 was to receive a specific quantity of one of the medications, by mouth once daily. The MAR also included specific directions for the preparation of this medication. Two days after the above-described observations, the documentation on resident #009's MAR was still indicative that resident #009's medications had not been administered.

During the inspection, Inspector #655 reviewed the health care record belonging to resident #009. At the time of the review, Inspector #655 found no written record outlining the plan of care related to resident #009's family member administering medications to the resident. There was no physician's order or any other provisions included in the resident's health care record.

During interviews, resident #009's family member indicated to Inspector #655 that they typically administer resident #009's medications to the resident after the nurse has prepared them, including the above-described medications which was to be prepared in accordance with specific directions. At the same time, resident #009's family member indicated to Inspector #665 that they had never been given any particular directions related to medication administration; and specifically, had not been informed of the specific directions related to this particular medication. According to resident #009's family member, there had been a history of nursing staff administering one of the medications to resident #009 without measuring it, resulting in amounts being administered to the resident which exceeded the prescribed dose. The family member further indicated to Inspector #655 that they prefer to administer the medications in order to "catch errors." Resident #009's family member described re-checking the amount of a specified medication provided to them for administration to the resident by the nursing staff. Resident #009's family member indicated to Inspector #655 that when the dose is given to them by the nursing staff, they transfer

the dose into a different cup to re-measure it. Resident #009's family member indicated that they then identify the correct amount, and "waste the rest" by pouring the excess drug out. At the same time, resident #009's family member indicated to Inspector #655 that there had been "no monitoring" by nursing staff to ensure that resident #009's medications had been administered by the family member after they were dispensed by the nurse.

During an interview, Consultant Pharmacist #105 indicated to Inspector #655 that the above-described medication is considered to be a high-risk medication.

In a policy titled "Medication Risk Management: High-Alert Medication Quick Facts" (Policy #8.12.0), revised July, 2014, it was indicated that the medication was a "high-alert" medication, meaning that it bears "a heightened risk of causing significant patient harm when they are used in error". The policy included information related to dosing and administration of the medication, as well as signs and symptoms to be monitored related to its use.

During an interview, DOC #103 indicated to Inspector #655 that the practice of having family members administer medications to residents is not consistent with the licensee's policy. At the same time, DOC #103 indicated that there were family members of residents' who resided on a particular unit in the home who had requested that they be the ones to administer medications to particular residents. During the same interview, DOC #103 indicated that where a family member has administered medications to a resident, the medications were to be signed off in the resident's MAR as having been administered only after they were administered. According to DOC #103, it remains the nurses' responsibility to confirm that the medication had in fact been administered whenever it is given by a family member. DOC #103 indicated that there was no requirement to have a physician's order for administration of a medication by family.

Two days after the initial observation (described above), the family member of resident #009 approached Inspector #655 in an area of the home which was not resident #009's home area. The family member reported to Inspector #655 that since the time of the above-described observation, they had been approached by someone in the home, at which time they were notified that there would be a physician's order implemented which would outline provisions for their involvement in the administration of medications to resident #009. On the same day, the family member

indicated to Inspector #655, they had been given the prepared medication to administer to the resident that day, but had not yet administered it.

Director of Resident Services (DRS) #106 indicated to Inspector #655 that nurses' are not expected to document that medications were administered to a resident on the resident's MAR when they were given to the resident by a family member because it cannot be documented this way "unless you have seen it yourself." According to DRS #106, a note would be made indicating that the medications were given to a family member for administration in the "medication notes." DRS #106 did not speak to the nurses' role in monitoring medication administration when a medication is given to a resident by a family member; and instead indicated to Inspector #655 that the expectation is that the family member would report back to the nurse if a medication had not been given.

Resident #009's medications (including a high-risk medication) were administered by a family member while the resident was in the long-term care home, without direction or monitoring by registered nursing staff.

In addition to the above described findings, over the course of the inspection, Inspector #655 found that resident #012's medication had also been administered by one of the resident's family members.

As such, the licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse, or a registered practical nurse.

ii. During the inspection, Inspector #655 observed a morning medication pass. Specifically, Inspector #655 observed RPN #100 administer medications to resident #003.

At the time of the observation, RPN #100 indicated to Inspector #655 that, sometimes, they ask another staff member to administer the medications to resident #003 after they are prepared because the resident is, at times, slow to ingest them. During an interview on the same day, RPN #100 indicated to Inspector #655 that some days, the resident takes "so long" to ingest the medications, that they advise a PSW to administer the medications to resident #003 while they feed the resident. RPN #100 stated during the interview, that when the resident is slow to ingest the

medications, they "can't be standing there" for the duration of the medication pass for resident #003.

During the inspection, PSW #101 asked Inspector #655 if PSWs were allowed to administer medications to resident's in the home. During the same interview, PSW #101 indicated to inspector #655 that the policy in the long-term care home related to a PSW's involvement in medication administration was "confusing" and "contradictory." When PSW #101 was asked if they had ever been asked to give a resident medications, the PSW indicated that "it depends." PSW #101 declined to elaborate.

During an interview, PSW #102 indicated to Inspector #655 that they are "sometimes" asked to give residents' their medications. PSW #102 indicated to Inspector #655 that if a resident has initially refused the medication, they may be asked; and, that when a medication is being administered to a resident in pudding or applesauce, they might be the staff assigned to spoon the medication to the resident.

During an interview, DOC #103 indicated to Inspector #655 that PSWs may be involved in administering medications to several residents after the medication is prepared by the nurse for reasons of behaviours or nurses' not having time to wait until the resident has ingested the medications.

Over the course of the inspection, DOC #103 indicated to Inspector #655 that the practice of having PSWs administer oral medications to residents in the home was not consistent with the licensee's policies. DOC #103 indicated to Inspector #655 that PSWs working in the home were trained on the administration of topical medications; but, that they received no other training related to medication administration.
The above-described findings related to the administration of medications by persons other than registered nursing staff, a physician, or dentist, present a risk for actual harm to residents. For this reason, the severity of the issue was determined to be a level 2. The scope of the issue was isolated; however, the licensee has a level 3 compliance history with multiple related findings of non-compliance:

- a written notification (WN), Compliance Order (CO), and Director's Referral (DR) was issued under O.Reg. 79/10, s. 131 (2), on September 10, 2018 (Resident

Quality Inspection, 2018_597655_0013),
- 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 (CO) will be issued.
(655)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 17, 2018

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_597655_0013, CO #001;

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. Ensure that medication reconciliation policies are complied with; and,

2. Continue to implement monitoring and remedial processes:

(a) At a minimum, adherence to the medication reconciliation policies by registered nursing staff will be measured after each admission or readmission to the long-term care home, for a period of four consecutive weeks.

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

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

Grounds / Motifs :

(A1)
1. The licensee has failed to comply with compliance order (CO) #001, issued in inspection report #2018_597655_0013, dated September 10, 2018, with a compliance date of November 7, 2018.

The licensee was ordered to:

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 licensee completed steps #1, 2, and 4.

The licensee failed to complete step #3 with regards to the medication reconciliation policies.

As such, the licensee has failed to ensure that where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy or protocol, that policy or protocol is 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.

A) Medication Reconciliation

Specifically, the licensee failed to ensure that the following policies and protocols related to medication reconciliation were complied with, despite having completed steps #1, 2, and 4 of CO #001 described above:

- "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),
- "Medication Reconciliation- Long Term Care Homes" (Policy Number 2.7.1), revised

December, 2016; and,
- The companion document titled "Revision to Medication Reconciliation Process" (the revision document) dated 2018.

Inspector #655 reviewed all three of the above-identified policies related to medication reconciliation in addition to the revision document. Over the course of the inspection, Inspector #655 also reviewed the medication reconciliation process with RPN #100, RPN #107, DOC #103, DRS #106, and Consultant Pharmacist #105.

According to the licensee's policies (including the above-described revision document), the medication reconciliation process includes the following steps:

- The nurse is to create a best possible medication history (BPMH) from all possible sources (at least two sources), during which time the resident or the resident's family (or, substitute decision-maker) may 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, and 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 transcribe all medication and treatment orders onto the MEDREC form as they are worded on the applicable medication list 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.

- On the MEDREC form, the resident label must be clearly visible, and all sections of the form including: gender, diet, allergies, and diagnosis are to be completed; and, all pages are to be numbered.

- 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 it (the admitting nurse) in the space allotted (labeled "Prepared by").

- A second nurse will sign beside the name of the nurse who prepared the MEDREC form, indicating that the prepared form was double-checked.

- The Admitting Nurse, or the nurse who prepared the MEDREC form, is then to contact the physician.

- The physician assesses the nurse prepared medication profile as recorded on the MEDREC form (and any supporting documents as applicable when/if on-site); and then provides direction to "continue", "discontinue", or "hold" each listed medication. This is to be documented on the MEDREC form first by checking the appropriate box "continue", discontinue", or "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 or new medication orders), are also to be documented in the appropriate section(s) on the form, as applicable. New orders are to be identified as such on the MEDREC form, with the medication list source in this case being "other". The nurse is also to draw a vertical line through all supplemental (blank or un-used) drug boxes on the MEDREC form.

- The Admitting nurse is to obtain consent before processing the orders, and must indicate that consent was obtained on the bottom of the MEDREC form.

- The MEDREC form and medication list sources are then to be faxed to the pharmacy. A copy of the fax report is to be kept with the MEDREC documents.

- The pharmacy service provider will only process the orders if the faxed MEDREC form is completed in full. If the MEDREC form that is received by the pharmacy service provider is incomplete, the pharmacy will contact the nurse and/or physician, as required.

- The admission or readmission orders that are outlined on the MEDREC form are entered into the electronic Medication Administration Record (eMAR) for the applicable resident, at which time, a third and then fourth nurse are to sign the

applicable MEDREC form as proof of verification that all orders on the MEDREC form are also in the eMAR.

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. In addition, the revisions to the medication reconciliation policies require that the resident's attending physician, upon their next visit to the home, reviews the resident's medical history including medication list sources and then sign and date each once they are reviewed.

At the time of the inspection, the medication reconciliation process done for any resident was being followed up upon by the completion of an internal audit by DOC #103, DRS #106 or delegate; and a subsequent audit by the consultant pharmacist within 2 weeks of the medication reconciliation process having been completed for a resident.

i) Inspector #655 reviewed the health care records including medication reconciliation forms and medication list sources for four residents (including resident #006 and resident #008) who were admitted or readmitted to the long-term care after the compliance due date of November 7, 2018. In addition, Inspector #655 reviewed the related internal and pharmacy audits that were completed with regards to the medication reconciliation process for the four residents. In two of the four cases reviewed, the information reviewed reflected an on-going lack of adherence with the licensee's medication reconciliation policies by staff.

>Resident #006

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 #006 was readmitted to the home from the hospital on November 9, 2018.

Inspector #655 reviewed the health care record belonging to resident #006.

According to the progress notes, resident #006 was hospitalized on November 4, 2018, and subsequently returned to the home on November 9, 2018, at approximately 2030 hours. According to a note entered on the same date by RN

#108, at 2143 hours, medication reconciliation had been completed for resident #006 following their readmission to the home, and a voice mail had been left for the on-call physician. According to an entry made by the same nurse at 2300 hours on the same day, the medication-reconciliation orders were confirmed by the physician. In the same note, it was indicated that the resident's discharge papers and reconciliation had been faxed to the pharmacy.

According to the progress notes, the medication reconciliation for resident #006 was checked with another nurse the following day, November 10, 2018.

That is, the accuracy of the information on the prepared MEDREC form was not verified by a second nurse before the orders were approved via a telephone order by a physician, contrary to the requirements outlined in the licensee's policies and revision document.

Inspector #655 reviewed the hospital records that were provided for resident #006 upon the resident's discharge from the hospital. One such record was titled "Prescription" and had been printed on November 9, 2018, at 1351 hours. Inspector #655 also reviewed the "Re-Admission Medication Reconciliation Order" (MEDREC) form which was initially pre-populated with the resident's pre-hospital medications and was observed to have been updated with additional medication orders following the residents return to the home. The form was prepared by RN #108 on November 9, 2018, according to the documentation on the form.

In comparing the two records, Inspector #655 found that, also contrary to the licensee's policies, not all orders had been transcribed onto the MEDREC form. The following discrepancies were found:

- The hospital prescription document included the following directions related to the medication, Trazodone: Trazodone 25 mg, oral, twice daily as needed (prn); while the MEDREC form included only the pre-hospital directions: Trazodone 25 mg by mouth twice a day as needed for agitation, and by mouth at bed time as needed. The MEDREC form did not include the hospital prescription.

- The hospital prescription document included the following directions related to the medication, Salbutamol: Salbultamol 2.5 mg/2.5ml solution, 2.5 mg to be inhaled twice daily, and, 2.5 mg to be inhaled every 6 hours when needed; while the

MEDREC form included only the pre-hospital directions: Salbutamol sulfate 1mg/1ml with directions to inhale he contents of one nebule twice a day; and to inhale the contents of one nebule every four hours as needed for shortness of breath, in addition to a regular dose. The MED-REC form did not include the hospital prescription.

As such, the above-described discrepancies between pre and post hospital orders related to Trazodone and Salbutamol were not reconciled or resolved at the time of the resident's readmission to the home.

On review of the above-described MEDREC form, it was further noted by Inspector #655 that there was no indication of which medication list sources had been used to complete the medication-reconciliation process; and, that the first nurses' signature for the completed review was not entered until November 12, 2018, with the second nurses' signature for the completed review not entered until November 18, 2018 – nine days after the resident was readmitted to the home. The process, including the required checks for accuracy, were not completed within the required timeframe.

Inspector #655 reviewed an internal audit (a document titled "Medication Reconciliation Audit") that was related to the medication reconciliation process completed for resident #006 when they were readmitted to the home on November 9, 2018. On the audit form, it was indicated that the audit had been completed by DOC #103 on November 10, 2018, the day after the MEDREC had been prepared, confirmed with the physician, and reportedly faxed to the pharmacy (according to the progress notes).

The results of the audit were indicative that the licensee's medication reconciliation policies had not been complied with in the following ways:

a) The prepared medication reconciliation form had not been signed by two different nurses,
b) The "reviewed and completed" medication reconciliation form had also not been signed by two different nurses,
c) There was no indication that the resident and/or the resident's substitute decision- maker (SDM) had been involved in the process of medication reconciliation,
d) Discrepancies were found related to the orders for Salbutamol and Escitalopram; and,

e) The pharmacy had not received the medication reconciliation orders on November 9, 2018.

Additional notes made on the audit form indicated that the Salbutamol orders needed to be clarified; and that the discrepancy related to Escitalopram was related to the order start date. In an additional note, it was indicated that the on-call pharmacist needed to be called first for after-hours medication-reconciliations (resident #006's re-admission medication reconciliation took place after-hours). There was no mention of a discrepancy related to the order for Trazodone on the internal audit form.

During the inspection, Inspector #655 also reviewed the "Q4 Medication Reconciliation Audit #7", completed by Consultant Pharmacist #105 on November 13, 2018, related to the medication reconciliation process that was done for resident #006 upon their readmission to the home on November 9, 2018. The results of the audit were indicative that the licensee's medication reconciliation policies had still not been complied with in the following ways:

a) The medication list sources used to create the best possible medication history were not identified on the MEDREC form,
b) The MEDREC orders were not signed and double-checked by nursing; and,
c) Not all Trazodone orders had been transcribed onto the MEDREC form, resulting in an unclarified discrepancy.

In an additional note on the audit form, it was indicated that both Trazodone orders – including the one that was identified in the hospital discharge records (prescription) and the pre-hospital order should have been transcribed onto the MEDREC form so that the discrepancy could be resolved in consultation with the physician. According to the note, one order would then be discontinued, and the other continued.

On review of resident #006's health care record, Inspector #655 found records that were indicative that all orders had been clarified by November 10, 2018 – the day that the internal audit had been completed by DOC #103 and one day following the resident's return to the long-term care home; with the exception of the Trazodone order.

Inspector #655 reviewed the Medication Administration Record (MAR) for resident #006, for the month of November, 2018, including the eMAR and a paper MAR that

had been temporarily utilized for resident #006 following their admission to the home. On the MAR, it was indicated that the resident was to receive Trazodone, 25 mg by mouth twice daily as needed for agitation and 25 mg at bedtime as needed. On review of the MAR, Inspector #655 noted that the resident had not received any Trazodone since they had returned to the home, and therefore there would have been no impact on the resident as a result of the failure to clarify the Trazodone order during the medication-reconciliation process.

During the inspection, Inspector #655 spoke with registered nursing staff on resident #006's resident home area. The staff who were interviewed also found no indication in the resident's health care record that the above-described discrepancy in the Trazodone order's had been clarified during the medication reconciliation process, or any time after (a period of approximately three weeks). The staff indicated that they would leave a note to ensure the order was clarified by the physician.

During an interview on December 5, 2018, order DRS #106 confirmed that the Trazodone had not been clarified until "recently".

The licensee failed to ensure that the medication reconciliation process was completed in accordance with the licensee's policies when resident #006 was readmitted to the home from the hospital on November 9, 2018.

>Resident #008

Inspector #655 reviewed the health care record belonging to resident #008.

In the resident's health care record, it was indicated that resident #008 was hospitalized on November 16, 2018, and subsequently returned to the home on November 18, 2018, at approximately 1330 hours.

Inspector #655 reviewed the MEDREC form which had been completed for resident #008 on November 18, 2018. The MEDREC form used in this case did not include a pre-populated list of pre-hospital medications.

Inspector #655 also reviewed the medication list sources which, in this case, would have included the resident's pre-hospital eMAR as well as the hospital discharge documents (hospital "notes" and "prescription").

The MEDREC form was prepared by RN #110. According to the documentation on the form, the prepared MEDREC had been reviewed (or double-checked) by RPN #107 on the same day.

On review of the MEDREC form, Inspector #655 noted that two additional nurses had signed the MEDREC form, also on November 18, 2018, in the sections labeled "First Check By" and "Second Check by". That is, the MEDREC form was reviewed by a total of four nurses on November 18, 2018, according to the documentation on the form.

Despite the above-described checks having been completed, several medications that would have been listed on the resident's pre-hospital e-MAR were omitted from the MEDREC form:

- Several (approximately 15) individual pre-hospital orders related to medications that were part of the long-term care home's "Medical Directives" were not recorded on the MEDREC form on November 18, 2018. It was instead indicated on the MEDREC form that "Medical Directives as per Villa Marconi LTC" were to be continued. However, this practice was contrary to the licensee's policies which required that each medication order be written exactly as it was indicated on the source document, including the medication name, strength, and dose, route of administration, frequency, and indication for use, if known at the time of admission. None of this information was documented on the MEDREC form for the 15 medications.
- Other pre-hospital medications were omitted, including: Budesonide, Clotrimazole (topical ointment), Hydromorphone (as needed), Mometasone (as needed), Voltaren (diclofenac) (as needed), Salbutamol Sulfate (as needed), Trazodone (as needed), and Insulin Aspart (as needed); and,
- The following interventions were missing on the MEDREC form: Blood glucose monitoring, continuous positive airway pressure (CPAP), and dietary interventions.

In addition to the above, it was found that:

- The hospital prescription document included the following directions related to the medication, Calcium Carbonate: Calcium Carbonate 1500 mg to be taken orally, three times daily; while the pre-hospital eMAR indicated that the resident was to receive Calcium Carbonate 500 mg orally, three times daily. The MEDREC form

included only the hospital order.

- The hospital prescription document included the following directions for the regular use of Insulin Apart: 25 units, subcutaneously once in the morning, and 12 units subcutaneously once in the evening; while the pre-hospital eMAR was indicative that prior to the hospitalization, the resident was to receive Insulin Aspart 40 units subcutaneously in the morning, and 15 units in the evening. The MEDREC form included only the hospital order.

On November 19, 2018, the above-described discrepancies involving Calcium Carbonate and Insulin Aspart were resolved. In both cases, the physician ordered that the hospital orders were to be discontinued; and that the pre-hospital orders (per the resident's eMAR) were to be continued instead. In addition, orders were obtained to continue/clarify the directions related to the other medications that had initially been omitted on the MEDREC form when it was prepared on November 18, 2018 (see above).

On review of resident #008's health care record, including progress notes, it was found that resident #008 had been given 1500 mg of Calcium Carbonate on November 18, 2018, in accordance with the hospital discharge documents; and, 12 units of Insulin Aspart in the evening of November 18, 2018, in accordance with the hospital discharge documents – before the orders (pre-hospital vs. hospital) had actually been clarified. However, all medications were clarified within 24 hours of the resident's admission, despite the transcription errors on the MEDREC form.

On review of the physician's orders, it was found that the orders for other interventions such as CPAP and specific dietary interventions had been clarified on November 20, 2018 – two days after the resident was readmitted to the home.

Inspector #655 reviewed an internal audit (a document titled "Medication Reconciliation Audit") that was related to the medication reconciliation process completed for resident #008 when they were readmitted to the home on November 18, 2018. On the audit form, it was indicated that the audit had been completed by DRS #106. The results of the audit were indicative that the licensee's medication reconciliation policies had not been complied with in the following ways:

a) The medication reconciliation was not completed using the appropriate Classic

Care Pharmacy medication reconciliation form (in this case, the yellow MEDREC form which would have included a pre-populated list of the resident's pre-hospital medications if used),
b) Two or more medication list sources had not been used to create the BPMH (hospital documents were not compared to the MAR or other source),
c) Discontinued medication orders were not clearly crossed out; and,
d) Discrepancies or errors were found.

Additional notes on the audit form were indicative that because the main source for the reconciliation was the hospital discharge documents, many medications were missed from the previous MAR, and discrepancies were also missed. According to the note on the medication audit form completed by DRS #106, "many clarifications and additions were made on regular order sheets as missing items or discrepancies were identified. As of today [November 20, 2018 – two days after the resident was readmitted], all orders have been clarified".

At the time of the inspection, there was no indication that the failure to comply with the licensee's medication reconciliation policies had otherwise reached the resident.

The incorrect MEDREC form (which did not include any pre-hospital medications) was used, and the resident's pre-hospital eMAR was not used as a second medication list source in order to create the best possible medication history when resident #008 returned to the home from the hospital.

As such, the licensee failed to ensure that the medication reconciliation process was completed in accordance with the licensee's policies when resident #008 was readmitted to the home from the hospital on November 18, 2018.

The above described findings present an on-going risk to residents related to a lack of adherence to the same policies related to medication reconciliation.

The 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 2 as there was potential for actual harm to residents as a result of a failure to comply with medication policies. The home has a level 4 compliance history, where continued non-compliance was identified with the original area of non-compliance:

- A written notification (WN), Compliance Order (CO), and Director Referral (DR) was issued in a Resident Quality Inspection Report (#2018_597655_0013), dated September 10, 2018.

As such, a compliance order (CO) will be re-issued under s. 8 (1) b) of O. Reg. 79/10.

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

(655)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 22, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2018_597655_0013, CO #002;

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 #006, #008, #010 and #011 receive their prescribed medications, in accordance with the directions for use specified by the prescriber.

Grounds / Motifs :

(A1)
1. The licensee has failed to comply with compliance order (CO) #002, issued in inspection report #2018_597655_0013, dated September 10, 2018, with a compliance date of November 7, 2018.

The licensee was ordered to:

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.or/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 licensee completed step #1 for the specific residents who were identified in CO #002. The licensee also completed step #2 and #3.

i. The licensee failed to complete step #1 for all readmitted residents (resident #006); and failed to ensure that drugs were administered to other residents (resident #008, #010 and #011) in accordance with the directions for use specified by the prescriber.

As such, the licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

>Resident #006:

Inspector #655 reviewed the health care record belonging to resident #006. According to the resident's health care record, resident #006 was hospitalized on November 4, 2018, and subsequently returned to the home on November 9, 2018, at approximately 2030 hours, at which time the resident's pre-hospital and post-hospital medications were reconciled, as described in WN #2.

At the time of the resident's return to the long-term care home, on November 9, 2018, several new orders were received, including an order for Perindopril (tablet form) in the amount of 2 mg, to be given to the resident, orally, once a day.

As described in WN #2, Inspector #655 reviewed the eMAR for resident #006 for the month of November, 2018, and a paper MAR that was used for resident #006 in the days following their readmission to the long-term care home on November 9, 2018.

On review of the above-noted records, Inspector #655 was not able to find any documentation which would indicate that the Perindopril had been administered, or offered, to resident #006 on November 10, 2018, the day after they were readmitted to the long-term care home.

During an interview, RPN #112 recalled working on resident #006's resident home area, and being assigned to administer resident #006's medications. RPN #112 further indicated to Inspector #655 that because resident #006 had been readmitted to the home after pharmacy hours, their medications had not been provided by the pharmacy as of November 10, 2018. RPN #112 indicated they were not sure that resident #006 had received their newly prescribed medication, Perindopril, on November 10, 2018, for this reason.

During an interview, RPN #100 recalled that although resident #006 had returned to the long-term care home from the hospital on November 9, 2018, their medications had not been received from the pharmacy service provider until 1120 hours on November 11, 2018 – two days later and over 24 hours after the resident was readmitted to the home. According to the above-described MARs, it was then that resident #006 first received the prescribed medication, Perindopril.

During an interview, DRS #106 indicated to Inspector #655 that when a resident returns to the home after-hours, or on a weekend, the pharmacy service provider does not always provide the resident's medications when needed.

The licensee was unable to demonstrate that resident #006 had received the medication, Perindopril, in accordance with the prescriber's directions on November 10, 2018- the day after they were readmitted to the long-term care home from the hospital.

As such, the licensee has failed to ensure that the drug, Perindopril, was administered to resident #006 in accordance with the directions for use specified by the prescriber.

>Resident #008

During the inspection, Inspector #655 reviewed a medication incident report (MIR)

related to an incident involving resident #008. The MIR described an omission error which occurred on November 14, 2018. According to the MIR, RPN #107 found all of resident #008's morning medications to have been left at the resident's bedside, not taken by the resident.

Inspector #655 reviewed resident #008's eMAR for the month of November, 2018; and specifically, for the day of the above-noted medication incident (November 14, 2018). Resident #008's eMAR included the following directions related to oral medications to be administered at the time of the incident (0800 hours, November 14, 2018):

- Acetaminophen, 650 mg, four times a day (0800, 1200, 1700, and 1800 hours).
- Acetylsalicylic Acid, 81 mg, once a day (0800 hours),
- Amiodarone hydrochloride, 200 mg, once a day (0800 hours),
- Calcium Carbonate, 500 mg, three times a day (0800, 1200, and 1700 hours),
- Carbamazepine 400 mg, twice a day (0800, and 2000 hours),
- Linagliptin, 5 mg, once daily (0800 hours),
- Metoprolol, 12.5 mg, three times a day (0800, 1700, and 2000 hours)
- Midodrine HCL, 5 mg, pre-dialysis (Monday, Wednesday, and Friday) (0800 hours),

- Pantoprazole, 40 mg, once daily (0800 hours); and,
- Replavite, one tablet daily (0800 hours).

During an interview, RPN #107 recalled the medication incident involving resident #008 as described above. RPN #107 indicated to inspector #655 that the night nurse was to provide resident #008 with their morning medications before the resident left for dialysis that morning. However, according to RPN #107, that morning, the medications were found by a PSW staff member to have been left at the resident's bedside. RPN #107 indicated to Inspector #655 that in response, they called the resident's physician who advised them to administer the morning medications to the resident upon return to the home and to hold the 1200 hour medications.

The medications that morning had already been signed off in the eMAR as having been administered, although they were not taken by the resident at that time.

On review the above-described eMAR, Inspector #655 noted that an entry made for the 1200 hour dose of Acetaminophen and of Calcium Carbonate, respectively, was

indicative that these two medications had not been administered on November 14, 2018, during the medication pass as a result of the omission error described above. Resident #008 therefore received Acetaminophen three times (as opposed to four times), and Calcium Carbonate two times (as opposed to three times) on the day of November 14, 2018. In addition, the entry made for the medication, Midodrine, was indicative that the medication was not given on that day at all.

Resident #008 did not receive Acetaminophen or Calcium Carbonate at the frequency required by the original physicians order; nor did the resident receive the medication, Midodrine, prior to dialysis on the morning of November 14, 2018.

As such, the licensee failed to ensure that resident #008's drugs were administered in accordance with the directions for use specified by the prescriber.

>Resident #010

During the inspection, Inspector #655 reviewed a medication incident report (MIR) related to an incident involving resident #010. The MIR described an administration error which occurred on November 10, 2018. According to the MIR, RPN #113 administered an extra dose of acetaminophen to resident #010, in error.

Inspector #655 reviewed the eMAR for resident #010 for the month of November, 2018; and specifically, for the day of the above-described incident (November 10, 2018).

According to the resident's eMAR, resident #010 was to be given a regular dose of Acetaminophen (500 mg four times daily, totaling 2000 mg (or, 2g)/day); and, 500 mg of Acetaminophen every 8 hours as needed, to a maximum of 3 g/day from all sources. This is clarified in a document titled "Villa Marconi Medical Directives" to mean a maximum of 3 g in 24 hours from all sources.

According to the documentation on resident #010's eMAR, resident #010 was given all of their regular doses of Acetaminophen on November 9 and November 10, 2018; and, in addition, they were given additional doses of Acetaminophen, in the amount of 500 mg, at 2239 hours on November 9, 2018, and again, in error, at 0014 hours on November 10, 2018. As a result, resident #010 received over 3 g of Acetaminophen in a 24 hour period.

During an interview, RPN #113 recalled the above-described medication incident. RPN #113 indicated to Inspector #655 that they had received no information during a shift report that night regarding resident #010 having received an additional dose of Acetaminophen (a prn, or as needed dose) just prior to their shift starting. RPN #113 indicated to Inspector #655 that just after midnight, resident #010 reported that they had a headache. RPN #113 further indicated to Inspector #655 that, in response, they offered the resident a dose of Acetaminophen. The resident agreed, and RPN #113 administered the medication. RPN #113 explained to Inspector #655 that they did not realize that the resident had already received a prn dose of Acetaminophen until they went to document in the eMAR. RPN #113 indicated that they should have checked the prn administration record prior to administering the Acetaminophen that night; but, didn't.

The licensee failed to ensure that resident #010's drugs were administered in accordance with the directions for use specified by the prescriber when they were given an extra dose of Acetaminophen, in error.

>Resident #011

During the inspection, Inspector #655 reviewed a medication incident report (MIR) related to an incident involving resident #011. The MIR described an omission error which occurred on November 15, 2018, but was discovered on November 16, 2018.

According to the MIR, resident #011's medications which were to be administered on November 15, 2018, at 0800 hours, were found to be in the original medication package in the medication cart at 2200 hours on November 16, 2018. In the MIR it is indicated that although the medications had been found in the medication cart, they had been signed off in the resident's eMAR as having been administered by RPN #107. According to the MIR, the following medications were involved: Citalopram (20 mg tab), Ferrous Fumarate (300 mg capsule), Irbesartan (75 mg tab), and Metformin (500 mg, 0.5 tab).

During an interview, RPN #107 recalled the MIR involving resident #011 as it is described above. RPN #107 explained that resident #011 had some medications stored in bottles, and some in pouches. RPN #107 indicated to Inspector #655 that resident #011's medications were crushed before administration, and mixed into

applesauce and/or a fruit spread. RPN #107 further indicated to Inspector #655 that on the day of the incident, a family member had spoken to them during the medication pass; and they did not realize that they had not added all of the medications to the applesauce. RPN #107 indicated to Inspector #655 that on the day of the incident, they had signed all medications off as having been administered because, at the time, they thought they had been. RPN #107 further indicated that the four medications noted above were later found by a colleague to still be in the medication cart.

On November 15, 2018, resident #011 did not receive the following prescribed medications: Citalopram, Ferrous Fumarate, Irbesartan, or the morning dose of Metformin.

As such, the licensee failed to ensure that resident #011's drugs were administered in accordance with the directions for use specified by the prescriber.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to a resident as a result of the medication incidents. 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 three out of three of the medication incidents that were reviewed during the inspection; in addition to an instance where a newly admitted resident was initially unable to be provided with a required medication. 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) in a Resident Quality Inspection Report (#2017_617148_0015) dated May 23, 2017,
- a written notification (WN) and Voluntary Plan of Correction (VPC) was issued under O. Reg. 79/10, s. 131 (2) in a Complaint Inspection Report (#2017_619550_0009), dated March 23, 2017,
- a written notification (WN) and Voluntary Plan of Correction (VPC) was issued under O. Reg. 79/10, s. 131 (2) in a Complaint Inspection Report (# 2017_619550_0010) dated March 27, 2017; and,
- a written notification (WN), compliance order (CO), and Director Referral (DR) was issued under O. Reg. 79/10, s. 131 (2) in a Resident Quality Inspection Report (#2018_597655_0013) dated September 10, 2018.

As such, a compliance order will be re-issued under s. 131 (2) of O. Reg. 79/10.

The above written notification is also being referred to the Director for further action by the Director.
(655)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

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

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

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

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

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by MICHELLE EDWARDS (655) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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