Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jun 21, 2017;	2017_589641_0004 (A1)	001784-17, 001785-17	Follow up

Licensee/Titulaire de permis

St. Joseph's at Fleming
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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

ST JOSEPH'S AT FLEMING
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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

CATHI KERR (641) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The home requested an extension for the compliance due dates for both CO #002 and #003 both related to medication administration. The extension requested is for July 21 2017 and this request has been granted.

Issued on this 21 day of June 2017 (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

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Ministère de la Santé et des Soins de longue durée

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

CATHI KERR (641) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): January 20, 26, 31, February 1, 2, 6, 2017

This inspection was conducted in reference to a follow up to Compliance Orders Log #001784-17 and Log #001785-17. Also inspected at this time were Critical Incidents Log #002333-17, Log #000361-17 and Log #035078-16, all related to medication incidents.

During the course of the inspection, the inspector(s) spoke with the Administrator (Admin), the Director of Care (DOC), Home Area Managers (HAM), Manager of Quality and Education, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Residents. As well, the Inspector observed residents and reviewed resident heath care records.

The following Inspection Protocols were used during this inspection:

Medication

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

- **2 WN(s)**
- **0 VPC(s)**
- **3 CO(s)**
- **0 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. 135. (1)	CO #001	2016_461552_0023	531

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed (b) corrective action is taken as necessary, and (c) a written record is kept of everything required under clauses (a) and (b).
Inspector #641 conducted a follow up inspection related to the above order issued on September 9, 2016 under Inspection #2016_461552_0023 with a compliance date of September 16, 2016.

The Manager of Quality and Education #100 generated a summary of all medication incidents that occurred in the home for a specified four month period. Inspector #641 reviewed the summary and found 12 medication incidents during that period that involved controlled substances or high risk medications. Inspector #641 requested from Home Area Manager (HAM) #102 and later from HAM #104, all documentation related to the home's review, analysis and corrective action taken related to these 12 incidents. There was no documentation received for the following five incidents.

1. Medication Incident ID #11692 was related to resident #008. This incident report indicated that on a specified date, the eMAR for this resident indicated that a specific medication was given but the count did not reflect that the medication had been removed from the medication card, indicating that the resident did not receive that dose. Inspector #641 reviewed the resident's progress notes and there was no note related to this omission or assessment of the resident after the omission was noted. No documentation was received from the home of a review, analysis or

report regarding this incident.

2. Medication Incident ID #11882 was related to resident #008. This incident report indicated that on a specified date a medication was signed for but not given. The eMAR was signed by the staff member but the medication had not been removed from the blister pack. The resident had confirmed that they had not received the medication at that time. The incident report further stated that an error occurred that affected the resident and required monitoring to confirm that it resulted in no harm to the resident and /or required intervention to preclude harm. The incident report indicated that the resident had been monitored all morning. Inspector #641 reviewed the resident's progress notes for that time period. Twenty-six minutes prior to the incident, there was a note indicating that the resident had no further complaints. At the time of the incident, the progress notes indicated that the resident had some complaints. Later that morning, the resident received another dose of the medication with no note attached. Seven hours after the incident, the resident again received a dose of the medication and the note indicated that the resident had requested it. No documentation was received from the home of a review, analysis or report regarding this incident.

3. Medication Incident ID #12213 was related to resident #009. This incident report indicated that on a specified date, a health care aide brought four medications to the nurse that had been found on the floor in the resident's room. The report indicated that these were more than likely a missed dose of resident #009's medications. Inspector #641 reviewed the resident's progress notes for that day which included a note regarding the medications being found on the floor and that the resident acknowledged dropping the pills. It also indicated that the doctor and resident's POA had been notified of the incident. There was no documentation of the resident receiving an assessment after the dose omission was found. No documentation was received from the home of a review, analysis or report regarding this incident.

4. Medication Incident ID #12516 was related to resident #010. This incident report indicated that on a specified date, the resident had not received a dose of medication as ordered. Inspector #641 reviewed resident #010's progress notes which indicated that no note had been charted related to this incident and no assessment had been done on the resident once the omission had been found. No documentation was received from the home of a review, analysis or report

regarding this incident.

5. Medication Incident ID #12463 was related to resident #013. This incident report indicated that on a specified date, it was noted that resident #013 had received a new order for a medication, that the resident was to receive the evening prior. The incident report further indicated that the error had reached the resident and required monitoring to confirm that it resulted in no harm to the resident and or required intervention to preclude harm. Inspector #641 reviewed the resident's progress notes which documented the dose not being given at the time ordered, but no documentation of monitoring the resident thereafter. No documentation was received from the home of a review, analysis or report regarding this incident.

The compliance order was re-issued as the scope demonstrated that there were five of the twelve separate medication incidences that did not have any documented review or analysis or identified any corrective action that was taken. The risk to the residents was high and the severity was high as well, as there were five out of 12 incidents that had no in-depth analysis that was documented by the home. [s. 135. (2)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. 1. The licensee has failed to ensure that no drug is used by or administered to resident #009, #016 and #018 unless the drug has been prescribed for the resident.

In reference to log #001784-17

The Medication Incident Notification reports were reviewed for a specified four month period. The "Medication Incident Notification" (MEDINC) for resident #009, #016 and #018 indicated that the residents were administered a drug that was not prescribed for the individual residents.

1. On a specified date, resident #009 (MEDINC12178) received a specific medication. A review of resident #009's Physician Orders indicated that the medication had been discontinued six weeks prior to the date it was given.

A review of the progress notes indicated that RPN #108 had documented that he administered the medication and then twenty minutes later, discovered that the order had been discontinued. The medication card was left in the medication bin in the med cart.

During an interview with RPN #107 he indicated that the Electronic Medication Administration Record (EMAR) was temporarily unavailable and he used the medication packaging to check the medication order prior to the administration of the medication. He indicated that on the specified date, he discovered that the medication had been discontinued. Because the medication card had not been removed from the cart, the resident was administered a discontinued dose of

medication. RPN #107 indicated that resident #009 was assessed, the physician was notified, acknowledged the error and to monitor the resident. RPN #107 indicated that resident #108 was monitored and had a comfortable night.

2. A review of resident #016's MEDINC13195 report, on a specified date, indicated that RPN #106 administered ten specific medications to resident #016. Resident #016 Physician Orders indicated that resident #016 was to receive eight different medications. MEDINC13195 indicated that the physician was notified and to monitor the resident.

On February 6, 2017, during an interview with RPN #105, she indicated that she and RPN#112 came to assist RPN #106. RPN #105 told inspector #531 that resident #017 reported that he/she had not received the morning medications. She indicated that both she and RPN #106 discovered that RPN #106 had administered the medication to resident #016 that were not prescribed for the resident. RPN # 105 indicated that the physician was notified and the resident was monitored. RPN #106 was unavailable for an interview as the RPN was no longer employed with the home.

3. Review of MEDINC11914 report, for a specified date, indicated that RPN #108 administered medications to resident #018 that were not prescribed for the resident. The on call physician was notified and advised to monitor for sedation, fall risk and encourage food.

Progress note for a specified date indicated RPN #018 documented that the on call physician was notified and reviewed medication error with the physician. The physician stated that the dose of the medication was low enough that it would not cause harm and to administer two other medications. A review of resident #018's Physician Orders for that date indicated that resident # 018 was to receive five different medications.

During an interview with Home Area Manager (HAM) #104 and review of the MEDINC report and progress notes, she indicated that RPN #108 reported that during the medication administration she discovered she had administered resident #007's medication to resident #018. RPN #108 documented that resident #018 received three medications that were not prescribed for the resident.

RPN #108 was not interviewed as she was on leave from duty.

On February 1, 2017 HAM #102 acknowledged the high number of medication administration errors and indicated that processes regarding the tracking of medication incidents, recording and follow up and identified gaps to improve the process. She indicated that the homes Pharmacy Consultant provides formal and informal education for registered staff and will continue to provide weekly in-services to registered staff where able and review medication incidents at the Physician Advisory Committee.

On February 6, 2016 the Director of Care indicated that the home is implementing a restructuring of the registered staff to increase the nursing compliment and thereby decreasing ratio between resident and registered staff and increased quality care.

Due to the widespread scope and ongoing risk of actual harm to residents related to medication and the homes non-compliance history, a compliance order is being issued. [s. 131. (1)]

2. 2. The licensee has failed to ensure that resident #003, #008, #013, #014 and #015 's drugs were administered in accordance to the directions for use specified by the prescriber.

The Medication Incident Notification " reports were reviewed for a specified four month period, which indicated that resident #003, #008, #013, #014 and #015's drugs were not administered in accordance with the directions specified by the prescriber.

Review of resident #003's Physicians Order for a specified date indicated that resident #003 received a specific medication twice daily and another medication once per day.
MEDINC13310 report indicated that RPN #110 administered the second medication to the resident instead of the first medication.

During an interview, RPN #110 indicated that she administered the wrong medication to the resident. RPN #110 indicated that the medications were not administered in accordance with the directions specified by the prescriber. RPN #110 indicated the physician was notified and that there were no adverse effects to the resident.

Review of resident #008's Physician Orders for a specified date, indicated that

resident #008 received a specific medication if required. The progress notes for that date indicated that the resident had received the medication. MEDINC11882 indicates that the medication was signed as given in the electronic medication administration record for resident #003. Further documentation for the medication was not signed and the medication was still in the resident's medication card. The resident confirmed not receiving the medication.

During an interview, RN #111 indicated that the dose omission was identified when the resident requested another dose of the medication. She indicated that resident #008 was monitored.

Review of Physician Orders for resident #013 indicated that on a specified date, the physician ordered a specific medication to start at that time. The MEDINC12463 indicated that the orders were not noted until the morning of the next day and that the medication was given at that time.

During an interview RN #111 indicated that the order was to start the evening before it was actually given. She indicated that the physician was notified and confirmed that the next evening dose could be administered at 2000. She indicated the resident was monitored and there were no adverse effects noted.

Review of resident #015's Physician Orders for a specified date indicated that the resident was prescribed a specific medication to be administered stat (immediate) then continue for the next two days. Review of the resident #015's EMAR record the order was transcribed for a later date.

MEDINC13123 indicates that resident #015 was ordered a stat dose of a specific medication then to continue the next 2 days. Resident was not administered medication stat dose as specified by the prescriber. The incident report indicates that the physician was notified and to monitor resident #015. During an interview, RN #111 indicated that resident #015 did not receive the stat dose of the medication. She indicated that resident #015 was monitored for further distress.

MEDINC11643 for resident #014 indicated that the resident received two doses of medications at the same time. The incident indicates that RPN #113 set all resident #013's medication packaging on the top of the medication cart and administered them at the same time. The RPN noticed that the medication had not been administered in accordance with directions specified by the prescriber and reported the incident.

Review of resident #014's MEDINC11643 indicated that the resident received three medications. The incident report further indicated that the physician was notified and the resident was monitored throughout the day.

Due to the widespread scope and ongoing risk of actual harm to residents related to medication and the homes non-compliance history, a compliance order is being issued. [s. 131. (2)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002,003

Issued on this 21 day of June 2017 (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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : CATHI KERR (641) - (A1)

Inspection No. / No de l'inspection : 2017_589641_0004 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 001784-17, 001785-17 (A1)

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Jun 21, 2017;(A1)

Licensee / Titulaire de permis : St. Joseph's at Fleming
659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8

LTC Home / Foyer de SLD : ST JOSEPH'S AT FLEMING
659 Brealey Drive, PETERBOROUGH, ON, K9K-2R8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Patrick Gillespie

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To St. Joseph's at Fleming, you are hereby required to comply with the following order (s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_461552_0023, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is hereby ordered to ensure that every medication incident related to a missing controlled substance or any other medications that bears a heightened risk of causing significant harm if used in error is subjected to an in-depth analysis, is documented and reported as required under O.Reg.79/10,s.135(2)

Grounds / Motifs :

1. 1. The licensee has failed to ensure that a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed (b) corrective action is taken as necessary, and (c) a written record is kept of everything required under clauses (a) and (b).
Inspector #641 conducted a follow up inspection related to the above order issued on September 9, 2016 under Inspection #2016_461552_0023 with a compliance date of September 16, 2016.

The Manager of Quality and Education #100 generated a summary of all medication incidents that occurred in the home for a specified four month period. Inspector #641 reviewed the summary and found 12 medication incidents during that period that involved controlled substances or high risk medications. Inspector #641 requested from Home Area Manager (HAM) #102 and later from HAM #104, all documentation related to the home's review, analysis and corrective action taken related to these 12 incidents. There was no documentation received for the following five incidents.

1. Medication Incident ID #11692 was related to resident #008. This incident report indicated that on a specified date, the eMAR for this resident indicated that a specific medication was given but the count did not reflect that the medication had been removed from the medication card, indicating that the resident did not receive that dose. Inspector #641 reviewed the resident's progress notes and there was no note related to this omission or assessment of the resident after the omission was noted. No documentation was received from the home of a review, analysis or report regarding this incident.

2. Medication Incident ID #11882 was related to resident #008. This incident report indicated that on a specified date a medication was signed for but not given. The eMAR was signed by the staff member but the medication had not been removed from the blister pack. The resident had confirmed that they had not received the medication at that time. The incident report further stated that an error occurred that affected the resident and required monitoring to confirm that it resulted in no harm to the resident and /or required intervention to preclude harm. The incident report indicated that the resident had been monitored all morning. Inspector #641 reviewed the resident's progress notes for that time period. Twenty-six minutes prior to the incident, there was a note indicating that the resident had no further complaints. At the time of the incident, the progress notes indicated that the resident had some complaints. Later that morning, the resident received another dose of the medication with no note attached. Seven hours after the incident, the resident again received a dose of the medication and the note indicated that the resident had requested it. No documentation was received from the home of a review, analysis or report regarding this incident.

3. Medication Incident ID #12213 was related to resident #009. This incident report indicated that on a specified date, a health care aide brought four medications to the

nurse that had been found on the floor in the resident's room. The report indicated that these were more than likely a missed dose of resident #009's medications. Inspector #641 reviewed the resident's progress notes for that day which included a note regarding the medications being found on the floor and that the resident acknowledged dropping the pills. It also indicated that the doctor and resident's POA had been notified of the incident. There was no documentation of the resident receiving an assessment after the dose omission was found. No documentation was received from the home of a review, analysis or report regarding this incident.

4. Medication Incident ID #12516 was related to resident #010. This incident report indicated that on a specified date, the resident had not received a dose of medication as ordered. Inspector #641 reviewed resident #010's progress notes which indicated that no note had been charted related to this incident and no assessment had been done on the resident once the omission had been found. No documentation was received from the home of a review, analysis or report regarding this incident.

5. Medication Incident ID #12463 was related to resident #013. This incident report indicated that on a specified date, it was noted that resident #013 had received a new order for a medication, that the resident was to receive the evening prior. The incident report further indicated that the error had reached the resident and required monitoring to confirm that it resulted in no harm to the resident and or required intervention to preclude harm. Inspector #641 reviewed the resident's progress notes which documented the dose not being given at the time ordered, but no documentation of monitoring the resident thereafter. No documentation was received from the home of a review, analysis or report regarding this incident.

The compliance order was re-issued as the scope demonstrated that there were five of the twelve separate medication incidences that did not have any documented review or analysis or identified any corrective action that was taken. The risk to the residents was high and the severity was high as well, as there were five out of 12 incidents that had no in-depth analysis that was documented by the home. [s. 135. (2)] (641)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Mar 10, 2017

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

a) Develop and implement a process focusing on ensuring medication issues related to the initial prescription orders, changes to prescription orders and the discontinuation of prescription orders.

Grounds / Motifs :

1. 1. 1. The licensee has failed to ensure that no drug is used by or administered to resident #009, #016 and #018 unless the drug has been prescribed for the resident.

In reference to log #001784-17

The Medication Incident Notification reports were reviewed for a specified four month period. The "Medication Incident Notification" (MEDINC) for resident #009, #016 and #018 indicated that the residents were administered a drug that was not prescribed

for the individual residents.

1. On a specified date, resident #009 (MEDINC12178) received a specific medication. A review of resident #009's Physician Orders indicated that the medication had been discontinued six weeks prior to the date it was given.

A review of the progress notes indicated that RPN #108 had documented that he administered the medication and then twenty minutes later, discovered that the order had been discontinued. The medication card was left in the medication bin in the med cart.

During an interview with RPN #107 he indicated that the Electronic Medication Administration Record (EMAR) was temporarily unavailable and he used the medication packaging to check the medication order prior to the administration of the medication. He indicated that on the specified date, he discovered that the medication had been discontinued. Because the medication card had not been removed from the cart, the resident was administered a discontinued dose of medication. RPN #107 indicated that resident #009 was assessed, the physician was notified, acknowledged the error and to monitor the resident. RPN #107 indicated that resident #108 was monitored and had a comfortable night.

2. A review of resident #016's MEDINC13195 report, on a specified date, indicated that RPN #106 administered ten specific medications to resident #016. Resident #016 Physician Orders indicated that resident #016 was to receive eight different medications. MEDINC13195 indicated that the physician was notified and to monitor the resident.

On February 6, 2017, during an interview with RPN #105, she indicated that she and RPN#112 came to assist RPN #106. RPN #105 told inspector #531 that resident #017 reported that he/she had not received the morning medications. She indicated that both she and RPN #106 discovered that RPN #106 had administered the medication to resident #016 that were not prescribed for the resident. RPN # 105 indicated that the physician was notified and the resident was monitored. RPN #106 was unavailable for an interview as the RPN was no longer employed with the home.

3. Review of MEDINC11914 report, for a specified date, indicated that RPN #108 administered medications to resident #018 that were not prescribed for the resident. The on call physician was notified and advised to monitor for sedation, fall risk and

encourage food.

Progress note for a specified date indicated RPN #018 documented that the on call physician was notified and reviewed medication error with the physician. The physician stated that the dose of the medication was low enough that it would not cause harm and to administer two other medications. A review of resident #018's Physician Orders for that date indicated that resident # 018 was to receive five different medications.

During an interview with Home Area Manager (HAM) #104 and review of the MEDINC report and progress notes, she indicated that RPN #108 reported that during the medication administration she discovered she had administered resident #007's medication to resident #018. RPN #108 documented that resident #018 received three medications that were not prescribed for the resident.

RPN #108 was not interviewed as she was on leave from duty.

On February 1, 2017 HAM #102 acknowledged the high number of medication administration errors and indicated that processes regarding the tracking of medication incidents, recording and follow up and identified gaps to improve the process. She indicated that the homes Pharmacy Consultant provides formal and informal education for registered staff and will continue to provide weekly in-services to registered staff where able and review medication incidents at the Physician Advisory Committee.

On February 6, 2016 the Director of Care indicated that the home is implementing a restructuring of the registered staff to increase the nursing compliment and thereby decreasing ratio between resident and registered staff and increased quality care.

Due to the widespread scope and ongoing risk of actual harm to residents related to medication and the homes non-compliance history, a compliance order is being issued. [s. 131. (1)]

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

(531)

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

Jul 21, 2017(A1)

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 shall:
a) Develop and implement a process to ensure that medication is administered to all residents in accordance with the directions for use, as specified by the prescriber; by assessing the medication routines to ensure efficiency and accuracy.
b) Educate all registered staff related to the College of Nurses of Ontario Medication Practice Standard, including administration of narcotics, the management of medication errors, and appropriate action to be taken in response to any medication error.

Grounds / Motifs :

1. 2. 2. The licensee has failed to ensure that resident #003, #008, #013, #014 and #015 's drugs were administered in accordance to the directions for use specified by the prescriber.

The Medication Incident Notification '' reports were reviewed for a specified four month period, which indicated that resident #003, #008, #013, #014 and #015's drugs were not administered in accordance with the directions specified by the prescriber.

Review of resident #003's Physicians Order for a specified date indicated that resident #003 received a specific medication twice daily and another medication once per day.
MEDINC13310 report indicated that RPN #110 administered the second medication to the resident instead of the first medication.

During an interview, RPN #110 indicated that she administered the wrong medication to the resident. RPN #110 indicated that the medications were not administered in accordance with the directions specified by the prescriber. RPN #110 indicated the physician was notified and that there were no adverse effects to the resident.

Review of resident #008's Physician Orders for a specified date, indicated that resident #008 received a specific medication if required. The progress notes for that date indicated that the resident had received the medication. MEDINC11882 indicates that the medication was signed as given in the electronic medication administration record for resident #003. Further documentation for the medication was not signed and the medication was still in the resident's medication card. The resident confirmed not receiving the medication.

During an interview, RN #111 indicated that the dose omission was identified when the resident requested another dose of the medication. She indicated that resident #008 was monitored.

Review of Physician Orders for resident #013 indicated that on a specified date, the physician ordered a specific medication to start at that time. The MEDINC12463 indicated that the orders were not noted until the morning of the next day and that the medication was given at that time.

During an interview RN #111 indicated that the order was to start the evening before

it was actually given. She indicated that the physician was notified and confirmed that the next evening dose could be administered at 2000. She indicated the resident was monitored and there were no adverse effects noted.

Review of resident #015's Physician Orders for a specified date indicated that the resident was prescribed a specific medication to be administered stat (immediate) then continue for the next two days. Review of the resident #015's EMAR record the order was transcribed for a later date.

MEDINC13123 indicates that resident #015 was ordered a stat dose of a specific medication then to continue the next 2 days. Resident was not administered medication stat dose as specified by the prescriber. The incident report indicates that the physician was notified and to monitor resident #015. During an interview, RN #111 indicated that resident #015 did not receive the stat dose of the medication. She indicated that resident #015 was monitored for further distress.

MEDINC11643 for resident #014 indicated that the resident received two doses of medications at the same time. The incident indicates that RPN #113 set all resident #013's medication packaging on the top of the medication cart and administered them at the same time. The RPN noticed that the medication had not been administered in accordance with directions specified by the prescriber and reported the incident.
Review of resident #014's MEDINC11643 indicated that the resident received three medications. The incident report further indicated that the physician was notified and the resident was monitored throughout the day.

Due to the widespread scope and ongoing risk of actual harm to residents related to medication and the homes non-compliance history, a compliance order is being issued. [s. 131. (2)] (531)

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

Jul 21, 2017(A1)

Ontario

Ministry of Health and Long-Term Care

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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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

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

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

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

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

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

Issued on this 21 day of June 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CATHI KERR - (A1)

Service Area Office /
Bureau régional de services : Ottawa