Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: July 4, 2023	
Original Report Issue Date: June 13, 2023	
Inspection Number: 2023-1442-0003 (A1)	
Inspection Type: Complaint Critical Incident System	
Licensee: The Rekai Centres	
Long Term Care Home and City: Wellesley Central Place,Toronto	
Amended By Kim Lee (741072)	**Inspector who Amended Digital Signature** Kim Lee (741072)

AMENDED INSPECTION SUMMARY

This report has been amended to:
Rescind Written Notice Notification #001 issued in the Original Licensee Report and add June 29, 2023, as an inspection date.

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Lead Inspector Kim Lee (741072)	**Additional Inspector(s)** Henry Chong (740836) Kirthiga Ravindran (000760) Elizabeth Cabral (000754)
Amended By Kim Lee (741072)	**Inspector who Amended Digital Signature** Kim Lee Digitally signed by Kim Lee Date: 2023.07.04 15:41:01 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
Rescind Written Notice Notification #001 issued in the Original Licensee Report and add June 29, 2023, as an inspection date.

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: May 23 - 26, 29 - 31, 2023 and June 1 - 2, 29, 2023.

The following intake was completed in this complaint inspection:

Intake #00086602 related to care concerns, dealing with complaints, transferring and positioning

techniques, neglect, and falls prevention

The following intakes were completed in this Critical Incident (CI) inspection:

Intake #00005537/CI#2959-000009-22 related to medication administration
Intake #00013705/CI#2959-000025-22 related to alleged staff-to-resident abuse
Intake #00020446/CI#2959-000004-23 related to resident-to-resident abuse, and behaviours
Intake #00017063/CI#2959-000030-22, and Intake #00008012/CI#2959-000019-22 were related to falls prevention and management

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

AMENDED INSPECTION RESULTS

COMPLIANCE ORDER CO #001 Changes in directions for administration

NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 136

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Following service of this order, the licensee shall:

1. Develop a written protocol to supplement existing policies that clearly instructs registered nursing staff in the process of completing the Long-Term Care Home (LTCH)'s quarterly medication review form.

2. Train all registered nursing staff in the aforementioned protocol.

3. Maintain a documented record for steps one and two, including the name and designation of staff, and date of training.

Grounds
The licensee has failed to ensure that a policy is developed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director, to govern changes in the administration of a drug due to modifications of directions for use made by a prescriber, including temporary discontinuation.

In accordance with Ontario Regulation 246/322 s.11(1)b 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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative, or system, is complied with.

Rationale and Summary
A resident required several changes in dosage of an identified medication over the quarter. An order was made to stop the medication. Two nursing staff signed the same day attesting to the preparation of the quarterly medication review for physician review, and two other nursing staff had signed the same day attesting that they had completed the review.

RN #119 stated that they had faxed the orders to discontinue the medication. RN #119 stated they did not know that the order faxed was not the current, active, order.

The LTCH's policy for Ordering Medication indicated that physician orders to discontinue drugs were to be faxed to the pharmacy so that the pharmacist would make necessary changes to the resident's record. RN #119 stated that because the electronic medication administration record (EMAR) was not updated, the medication continued to be administered.

The medication continued to be administered for two consecutive days by RPN #115 and RN #122, respectively.

Director of Nursing Services (DNS) #101 stated that during quarterly medication review, when new medication orders are given, three nurses are required at different points to review. The purpose is to review the new orders given, that they are updated, and reflected in the EMAR. DNS #101 stated that staff did not follow the LTCH's policy for discontinuing the medication order. DNS #101 stated that in addition to nursing staff, the pharmacy failed to recognize that the medication review attempted to discontinue orders that were not active. DNS #101 acknowledged that the medication continued to be

administered for two instances following the order to discontinue it. DNS #101 stated that the order should have been discontinued immediately because it posed a risk of an adverse event to the resident.

During the medication review process, registered nursing staff failed to follow the LTCH's policy to perform the activities to ensure that the medication ordered, was the correct medication discontinued. The resident continued to receive a medication that was no longer indicated for two days and experienced a subsequent adverse event.

Sources: Interview with staff, resident's medication record and progress notes, LTCH policies: Medication Review Program, Ordering Medications [741072]

This order must be complied with by July 21, 2023

COMPLIANCE ORDER CO #002 Administration of drugs

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 140 (1)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Following service of this order, the licensee shall:

1. Review the following processes with all registered nursing staff in the home:
- steps in receiving a medication order,
- transcribing a medication order,
- communicating the order to pharmacy,
- validating that the order is reflected in the EMAR as originally ordered, and
- the individual responsibilities as the first nurse, second nurse, and any other roles involved with the transcription and verification of medication orders and modifications of directions for use

2. Maintain a documented record for step one, including the name and designation of staff, and date of training.

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

Rationale and Summary

RN #119 stated they transcribed and faxed an order to discontinue a resident's current medication order. RN #119 stated they did not know that the active order was not the order that the RN had faxed to be discontinued. Because the EMAR was not updated, the medication continued to be administered when it should not have been.

RN #122 administered the medication to the resident, two days after the order was made to discontinue the medication. RN #122 stated that they administered the medication because the order was active in the EMAR at the time of administration. RN #122 stated that the resident experienced an adverse event following administration of the medication. In response, RN #122 stated that they enacted an LTCH protocol, which included the administration of another medication. RN #122 stated that an order was required to administer that medication and believed that an active order was in place at that time of the adverse event.

RN #119, RN #122 and DNS #101 stated that the medication to be discontinued was a high-alert medication. The LTCH's policy document listed that medication as a high-alert medication within the area of specialized control. RN #119 stated that the medication was a high-alert drug requiring double-checking with other nursing staff. DNS #101 acknowledged that the medication continued to be administered for two instances to the resident following the order to discontinue it. DNS #101 stated this was not a reasonable length of time to discontinue this specific order because it posed a risk of an adverse event to the resident.

The discontinued medication was administered for two consecutive days, by RPN #115 and RN #122, respectively. A second medication that had also been discontinued was also administered to the resident. In these instances, there were no active orders by way of prescription or medical directive to administer these medications to the resident.

In administering a medication that was not ordered for the resident, the resident experienced an adverse event.

Sources: staff interviews, resident's Medication Administration Record, LTCH policies: High-Alert Medications, Medical Directives, Medication Review Program [741072]

This order must be complied with by July 21, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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