Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 13, 2015	2015_433625_0002	008189-15	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

PINEWOOD COURT
2625 WALSH STREET EAST THUNDER BAY ON P7E 2E5

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

KATHERINE BARCA (625), JULIE KUORIKOSKI (621)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 29, 30, October 1, 2, 5 and 6, 2015.

Three logs were reviewed as part of this inspection. A Complaint inspection and a Follow Up inspection were also conducted concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Acting Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Residents and Family Members.

Throughout the inspection, the inspectors conducted a walk through of resident care areas, directly observed the delivery of care and services to residents, reviewed resident health care records and reviewed various home policies.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber, including the number

of doses administered and administration times.

Inspector #625 reviewed the health care record for resident #003 as well as the Critical Incident Report that was submitted to the Director in the summer of 2015. The report indicated that resident #003 was sent to hospital after receiving medications that exceeded the number of doses ordered by the physician and that were administered outside of the medication administration times. Documentation reflected that the resident had adverse effects from the medication requiring the resident to be transferred to hospital.

Inspector #625 reviewed the health care record for resident #003 including:
- a physician’s order for a specific number of doses of medication;
- a physician’s order sheet that identified the number of doses ordered was administered;
- a progress note that identified one additional medication dose was administered.

During an interview by Inspector #625, RPN S#121 confirmed that they administered the additional medication dose as documented. RPN S#121 reviewed the physician’s order sheet and confirmed that it stated the number of doses of medication ordered had been administered and that they administered the additional dose, for which there was no order.

Inspector #625 interviewed the Director of Care (DOC) who reviewed the physician's order entries and progress note documentation.The DOC confirmed that a medication error had occurred whereby resident #003 received an additional medication dose for which there was no order.

Inspector #625 reviewed the home's policy LTC-F-20 titled "Medication/Treatment Standards, Medication Administration" last revised August 2012. The policy stated that scheduled medications were to be administered according to standard medication administration times and that medications should be given within 60 minutes prior to and 60 minutes after these scheduled times.

The Medication Administration Record (MAR) for resident #003, reviewed by Inspector #625, indicated that the resident was to receive scheduled medications at three separate times.

Documentation by RPN #121 indicated that they had administered all of the medications, scheduled for three separate times, at once. In addition, the documentation indicated that

medications ordered for use as needed, were also administered with the scheduled medications. It was also documented that resident #003 experienced adverse effects from the medication, the physician attended the home to assess the resident, and the resident was sent to hospital.

RPN #121 reported to the Inspector that they had administered resident #003's medications that were scheduled for three separate times, as well as the prn medications, all at the same time.

The DOC was interviewed and identified the scheduled medication pass time and stated that medications should be administered one hour before or one hour after scheduled medication times. The DOC reviewed the documentation for resident #003 and stated that the medications for three separate scheduled times were administered all at one time.

Therefore, medications were administered 105 minutes (1.75 hours) earlier and 165 minutes (2.75 hours) earlier than the administration times scheduled. The administration of these medications was not within the specified time frame of 60 minutes prior to the scheduled administration time outlined in the home's policy.

The home does not have a history of previous non-compliance related to this finding and the scope is isolated. The decision to issue an order was based on the severity of the incident where the resident suffered actual harm and was transferred to hospital as a result. [s. 131. (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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy promoting zero tolerance of abuse and neglect of residents was complied with, specifically that any form of abuse by any person interacting with residents will not be tolerated.

A Critical Incident Report indicated that, during the spring of 2015, S#101 attempted to assist resident #002 to prepare for bed. The report outlined that resident #002 alleged an employee hurt the resident during care and called the resident a bad name. Resident #002 rang the call bell for assistance from other staff during this interaction. Additional documentation stated that resident #002 was observed to be crying and shaking afterwards. They stated it was the worst day of their life and continued to verbalize their feelings to staff after the incident.

Inspector #625 reviewed the licensee's policy "LP-C-20-ON Resident Non-Abuse – Ontario" last revised September 2014 that stated that any form of abuse will not be tolerated by the licensee. Verbal abuse was defined as verbal communication of a threatening or intimidating nature that diminishes a resident's sense of well-being, dignity or self-worth, inappropriate tone of voice was listed as an example. Physical abuse was defined as the use of physical force by anyone other than a resident that causes physical injury or pain, rough handling was listed as an example. Emotional abuse was defined as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, name calling and instilling fear were listed as examples.

Inspector #625 reviewed an email where resident #002 notified the Resident Services Coordinator S#113 about an incident that occurred. The resident stated that:
- what S#101 did during care hurt the resident and the resident asked the employee to stop;
- S#101 called the resident bad names but the exact words could not be recalled;
- resident #002 rang the call bell during care with S#101 in the room and stated someone needed to come and rescue the resident from the employee;

- S#101 left the resident's room and threw the resident's clothes on the bed;
- the date that this occurred was the worst day in resident #002's life.

An investigation was conducted by the home regarding the incident and S#101 was interviewed by the Executive Director and DOC. Interview notes reviewed by Inspector #625 indicated that S#101 stated resident #002 said "ow, you hurt me" referring to an injury the resident had sustained previously, the resident cried when stating their body was hurting, the resident was crying and shaking when another worker entered the room.

A letter on file signed by the DOC was reviewed by Inspector #625 and stated that S#101 admitted to being frustrated while assisting resident #002, the resident complained of pain and the employee did not recall the injury the resident had sustained prior to this incident and the employee would try to be calmer in the future.

Inspector #625 conducted an interview about the incident with resident #002's family member. The family member said resident #002 told the family member S#101 had been abusive to the resident, S#101 yelled at the resident to the point where the resident was scared, S#101 threw a piece of resident #002's clothing down on the bed and the resident had been fearful.

Inspector #625 interviewed S#101 about the incident. S#101 said that resident #002 stated the employee was being rough and, when the employee removed the resident's clothing, the resident said "ow, ow, ow" and that the employee was hurting the resident. S#101 stated they forgot about the resident's previously sustained injury. S#101 said their voice may have been raised in frustration and that they should have walked away from the resident sooner.

Inspector #625 conducted an interview about the incident with the DOC. The DOC verified findings from the investigation including that resident #002 had a documented injury and told S#101 to "stop, you're hurting me", the employee did not know about/recall the resident's prior injury at the time and that S#101 admitted to throwing the resident's clothing on the bed.

The home does not have a history of previous non-compliance related to this finding and the scope is isolated. The severity was determined to be actual harm or risk. [s. 20. (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 that ensures there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that equipment, supplies and devices for the falls prevention and management program are readily available at the home, specifically bed alarm falls prevention equipment.

Inspector #625 observed that three residents did not have falls prevention equipment, despite interventions documented in each resident's care plan that stated the equipment was in use.

The current care plan for resident #003 indicated a bed alarm as a required intervention.

The current care plan for resident #012 indicated a bed sensor alarm as a required intervention.

The current care plan for resident #013 indicated a bed alarm when in bed as a required intervention.

Inspector #625 observed that resident #003 did not have a bed alarm on the resident's bed.

Inspector #625 interviewed PSW S#119 at approximately 1500 hrs. S#119 stated that resident #003 did not have a bed alarm in place, resident #012 and resident #013 had parts of bed alarm systems in their rooms, but the bed alarms were not functional. S#119 stated that all three residents were waiting for bed alarm equipment and that registered nursing staff had previously been notified.

At approximately 1515 hrs, Inspector #625 asked PSW S#117 to review care plans for residents #003, #012 and #013, to identify the falls prevention equipment interventions listed in each resident's care plan and to attend each resident's room with Inspector #625 to view the falls prevention interventions in use.

S#117 reviewed the care plan for resident #003 which stated that resident required a bed alarm. PSW attended the resident's room and stated that no bed alarm falls prevention equipment was in place in the room.

S#117 reviewed the care plan for resident #012 which stated that resident required a bed sensor alarm. PSW attended the resident's room, searched for bed alarm equipment and stated that parts of the system were available but the alarm was not able to function.

S#117 reviewed the care plan for resident #013 which stated that resident required a bed alarm and a chair alarm. PSW attended the resident's room and stated that parts of the bed alarm system were in the room but the alarm was not functional.

S# 117 further stated that it had been a minimum of two weeks since they were aware of the need for bed alarm equipment for various residents and had notified those involved in obtaining it.

Inspector #625 spoke with the Executive Director who stated that they were aware that some bed alarm components were on back order but they did not know how many residents were impacted by the back order.

The scope of this issue demonstrated a pattern of not providing required falls prevention equipment to residents. The severity was determined to be a potential for actual harm to the residents involved. There was previous unrelated non-compliance issued to the licensee. [s. 49. (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 that ensures that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home, to be implemented voluntarily.

WN #4: 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 all medication incidents and adverse drug reactions are documented, reviewed and analyzed and that a written record is kept of everything required.

In the spring of 2015, resident #003 was sent to hospital following an adverse drug reaction where the resident experienced adverse effects from medications administered. The DOC was not able to provide a written record related to the review and analysis of this adverse drug reaction.

A Critical Incident Report was submitted that described a medication incident/adverse drug reaction that occurred. The report stated that resident #003 had experienced adverse effects after receiving doses of several medications.

A review of resident #003's health care record by Inspector #625 revealed that:

- a physician's order for resident #003 provided for administration a medication a set number of times. An additional dose of the medication was administered to resident #003 as indicated on physician's orders sheets and in charting;
- registered nursing staff did not process or record the administration of any of the doses of medication on the MAR as the MediSystem Pharmacy Manual policy Index Number 04 -02-12 titled "Medication Pass – MAR/TAR System" last reviewed June 23, 2014 indicated is required;
- the home's policy LTC-F-20 titled "Medication/Treatment Standards, Medication Administration" last revised August 2012 stated that scheduled medications were to be administered according to standard medication administration times and that medications should be given within 60 minutes prior to and 60 minutes after these scheduled times. Resident #003 was administered medications scheduled scheduled for three separate medication times, all at once.
- resident #003 had been administered multiple medications ordered for administration on an as needed basis within 30 minutes of each other.

Inspector #625 interviewed RPN S#121 who confirmed they administered various medications as listed above to resident #003 all within 70 minutes of each other.

Inspector #625 interviewed the DOC who stated there was no documentation of the medication incident as staff did not submit a medication incident report to the DOC at the time of the occurrence. The DOC also stated that there was no documentation of the discussion that occurred between the DOC and S#121 regarding the medication incident. During the interview with Inspector #625, the DOC was not aware that an additional dose of medication had been administered without an order to do so, that staff had not documented administration on the MAR as required by home's policy, or that scheduled medications were administered outside of the 60 minute range permitted by home's policy.

The home does not have a history of previous non-compliance related to this finding and the scope is isolated. This incident's severity has been determined to be the potential for actual harm to occur. [s. 135. (2)]

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 that ensures all medication incidents and adverse drug reactions are documented, reviewed and analyzed, and a written record is kept of everything required, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and that these doors were kept closed and locked when they were not being supervised by staff.

At 1817 hrs, Inspector #625 observed the door to the soiled utility room on a resident home area held open with a doorstop.

At 1822 hrs, Inspector #625 observed resident #015 enter the soiled utility room and place wet towels in the laundry cart located in the soiled utility room.

At approximately 1824 hrs, RPN S#121 walked by the soiled utility room in which resident #015 and Inspector #625 stood. RPN then assisted the resident to exit the room.

Inspector #625 asked S#121 if residents were permitted access to the soiled utility room. S#121 stated that items were kept in the soiled utility room that residents were not permitted access to and identified two bottles of "All Purpose Disinfectant Cleaner" found under the sink in an unlocked cupboard as such an item. S#121 stated that the door to the soiled utility room should be kept locked.

The home was issued a written notice from inspection number 2015_269597_0005 conducted April 7, 2015 related to r. 9. (1) 2. The scope is isolated and this incident's severity has been determined to be the potential for actual harm to occur. [s. 9. (1) 2.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included actions taken in response to the incident, specifically the outcome or current status of the individual or individuals who were involved in the incident.

A Critical Incident Report indicated, that in the spring of 2015, PSW S#101 attempted to assist resident #002 with evening care. The report outlined that resident #002 alleged S#101 hurt the resident during care and called the resident a bad name. Resident #002 rang the call bell for assistance from other staff during this interaction and S#101 threw resident #002's clothes on the resident's bed when exiting the room.

The report to the Director stated "Resident does not want police intervention" as the outcome/current status of resident #002 but, does not list any other information regarding the resident's status.

Documentation reviewed by Inspector #625 indicated that resident #002 was crying and shaking after the incident and stated that it was the worst day of the resident's life.

Inspector #625 conducted an interview about the incident with resident #002's family member. The family member said resident #002 told the family member S#101 yelled at the resident to the point where the resident was scared and fearful.

During an interview with Inspector #625 and S#101, S#101 stated that the resident could not stop speaking about the incident to other employees.

Inspector #625 conducted an interview with the DOC. The DOC stated that, after the incident with S#101, resident #002 continued to speak with staff about the incident, verbalizing what occurred.

The report to the Director did not provide the current status of the resident involved as known to the licensee including the resident's continued vocalization about the incident and the physical and emotional status of the resident with respect to this incident.

The home does not have a history of previous non-compliance related to this finding and the scope is isolated. The severity was determined to be minimal risk. [s. 104. (1) 3.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of a medication incident or adverse drug reaction in respect of which a resident is taken to hospital.

In the summer of 2015, resident #003 was sent to hospital after receiving medications that exceeded the number of doses ordered by the physician and were administered outside of scheduled medication administration times. Resident #003 was also administered multiple medications ordered for use as needed (prn) within an eight hour time period. Documentation reflected that the resident experienced adverse effects from the medication, requiring the resident to be transferred to hospital. The Director was not notified of this incident within one business day.

Inspector #625 interviewed the DOC who said that they were not aware of the incident at the time it happened and learned of at a later date. The DOC submitted a Critical Incident Report 37 days after the incident occurred. As a result, the Director was not notified within one business day after the occurrence of a medication incident or adverse drug reaction in respect of which a resident is taken to hospital.

The home does not have a history of previous non-compliance related to this finding, the scope is isolated and the severity has been determined to be minimal risk. [s. 107. (3)]

Issued on this 8th day of December, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHERINE BARCA (625), JULIE KUORIKOSKI (621)
Inspection No. / No de l'inspection :	2015_433625_0002
Log No. / Registre no:	008189-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 13, 2015
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	PINEWOOD COURT 2625 WALSH STREET EAST, THUNDER BAY, ON, P7E-2E5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CHERYL GRANT

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Ontario

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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) Ensure that drugs are administered to resident #003, and every other resident living in the home, in accordance with the directions for use specified by the prescriber including, but not limited to, the correct number of doses, the correct administration times and the correct instructions for use.
(b) Ensure all registered nursing staff are familiar with and adhere to the licensee's policies governing the processing of medication orders and administration of medications.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber, including the number of doses administered and administration times.

Inspector #625 reviewed the health care record for resident #003 as well as the Critical Incident Report that was submitted to the Director in the summer of 2015. The report indicated that resident #003 was sent to hospital after receiving medications that exceeded the number of doses ordered by the physician and that were administered outside of the medication administration times. Documentation reflected that the resident had adverse effects from the medication requiring the resident to be transferred to hospital.

Inspector #625 reviewed the health care record for resident #003 including:
- a physician's order for a specific number of doses of medication;
- a physician's order sheet that identified the number of doses ordered was administered;
- a progress note that identified one additional medication dose was

administered.

During an interview by Inspector #625, RPN S#121 confirmed that they administered the additional medication dose as documented. RPN S#121 reviewed the physician's order sheet and confirmed that it stated the number of doses of medication ordered had been administered and that they administered the additional dose, for which there was no order.

Inspector #625 interviewed the Director of Care (DOC) who reviewed the physician's order entries and progress note documentation.The DOC confirmed that a medication error had occurred whereby resident #003 received an additional medication dose for which there was no order.

Inspector #625 reviewed the home's policy LTC-F-20 titled "Medication/Treatment Standards, Medication Administration" last revised August 2012. The policy stated that scheduled medications were to be administered according to standard medication administration times and that medications should be given within 60 minutes prior to and 60 minutes after these scheduled times.

The Medication Administration Record (MAR) for resident #003, reviewed by Inspector #625, indicated that the resident was to receive scheduled medications at three separate times.

Documentation by RPN #121 indicated that they had administered all of the medications, scheduled for three separate times, at once. In addition, the documentation indicated that medications ordered for use as needed, were also administered with the scheduled medications. It was also documented that resident #003 experienced adverse effects from the medication, the physician attended the home to assess the resident, and the resident was sent to hospital.

RPN #121 reported to the Inspector that they had administered resident #003's medications that were scheduled for three separate times, as well as the prn medications, all at the same time.

The DOC was interviewed and identified the scheduled medication pass time and stated that medications should be administered one hour before or one hour after scheduled medication times. The DOC reviewed the documentation for resident #003 and stated that the medications for three separate scheduled

times were administered all at one time.

Therefore, medications were administered 105 minutes (1.75 hours) earlier and 165 minutes (2.75 hours) earlier than the administration times scheduled. The administration of these medications was not within the specified time frame of 60 minutes prior to the scheduled administration time outlined in the home's policy.

The home does not have a history of previous non-compliance related to this finding and the scope is isolated. The decision to issue an order was based on the severity of the incident where the resident suffered actual harm and was transferred to hospital as a result. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 04, 2015

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
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

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

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

Issued on this 13th day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Katherine Barca

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