Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 16, 2020	2020_679687_0005	023376-19	Follow up

Licensee/Titulaire de permis

St. Joseph's Health Centre of Sudbury
1140 South Bay Road SUDBURY ON P3E 0B6

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

St. Gabriel's Villa of Sudbury
4690 Municipal Road 15 Chelmsford ON P0M 1L0

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

LOVIRIZA CALUZA (687), KEARA CRONIN (759)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 1, 8-12, 15-18, and 23 -26, 2020.

The following intake was inspected during this Follow-up Inspection.

- A follow-up intake for Compliance Order (CO) #001, issued during inspection report #2019_671684_0040 under s. 131 (2) of Ontario Regulation (O. Reg.) 79/10, related to a medication administered to a resident not in accordance with the directions specified by the prescriber.

A Complaint Inspection #2020_679687_0007 and a Critical Incident System (CIS) Inspection #2020_679687_0006 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Acting Director of Care (ADOC), Food Service Manager (FSM), Physician, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Minimum Data Set (MDS) Coder, Personal Care Assistants (PCAs), Food Service Assistants (FSAs) and the Cook.

The Inspector(s) also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health records, staffing schedules, internal investigations and the home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication

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

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

Specifically failed to comply with the following:

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

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.

Compliance Order (CO) #001 was issued to the home in inspection report #2019_671684_0040. The home was ordered to be compliant with subsection 131 (2) of Ontario Regulation 79/10.

Specifically, the home was ordered that they must:

a) Re-educate all registered staff on safe medication administration practices.

b) Educate all registered staff on medical indicator monitoring, focusing on what to do when the medical indicators are not within the therapeutic range.

c) Complete medication incidents for all identified errors, upon completion of medication incident reports, review all medication incidents noting trends, risks, areas for improvement and re-evaluate quarterly.

e) Develop and conduct weekly audits to ensure accuracy of medication administration for each resident that receives the identified medication for the next three months. Maintain a record of the audits that are conducted.

While the licensee complied with steps a) through e), non compliance was identified related to medication administration, specific to the medical indicator parameters and medication administration.

1) Inspector #759 reviewed the home’s medication incident tracking form from January to March 2020, and identified a medication incident.

Inspector #759 further reviewed the document titled “Medication Incident: Original Report – MEDINC #46647”, which was reported by Registered Nurse (RN) #140. The medication incident report indicated that an RPN had administered a specified medication to resident #005, which was outside of the physician ordered parameters.

A review of the “Digital Prescriber’s Orders” document conducted by Inspector #759, indicated that resident #005 had a written physician’s order for the identified medication.

Inspector #759 reviewed resident #005’s electronic Medication Administration Record

(eMAR) for January 2020, and identified a physician's order. The Inspector further reviewed the eMAR and identified that the specified medication was administered twice when resident #005's medical indicator was outside of the physician ordered parameters.

Inspector #759 reviewed the home's policy "The Medication Pass", last revised January 2018, Section 3, Policy 3-6. The policy stated "All medications administered were listed on the resident's medication administration record (MAR). Each resident received the correct medication in the correct prescribed dosage, at the correct time, and by the correct route. The right resident received the right medication (not expired) of the right dose, at the right time, by the right route for the right reason and completed by the right documentation".

In an interview conducted by Inspector #687 with RPN #102, the RPN stated that they had administered resident #005's medication on a specified date. The RPN further stated that they did not notice the additional direction in the eMAR at that time, and that resident #005's medication should have been held.

During an interview conducted by Inspector #687 with RN #106, the RN indicated that the registered staff were to ensure not to give the specified medication to a resident if their medical indicator was outside of the physician ordered parameters.

Inspector #759 conducted an interview with Physician #139, they both reviewed resident #005's physician ordered medication which included the parameters. The Inspector further reviewed the medication incident which occurred on two separate dates with the physician. The physician stated that "If the [specified medication order] indicated to hold the medication due to [a medical indicator that was outside of the parameters], it would be expected that the medication would be held".

During an interview conducted by Inspector #759 with the Assistant Director of Care (ADOC), the ADOC verified that on the two separate dates, the specified medication was administered to resident #005, which was outside of the parameters ordered by the physician.

2) Inspector #759 reviewed the home's medication incident tracking form from January to March 2020, and identified that a medication incident.

During a review of a document titled "Medication Incident: Original Report - MEDINC #46043", Inspector #759 identified that a Nurse had administered a specified medication

outside of the physician ordered parameters to resident #010.

A review of the "Digital Prescriber's Orders" document conducted by Inspector #759, indicated that resident #010 had a written physician's order for the identified medication.

A review of resident #010's eMAR for January 2020, Inspector #759 identified a physician's order for the specified medication. The Inspector further reviewed the eMAR and identified that the specified medication was administered twice when resident #010's medical indicator was outside of the physician ordered parameters.

Inspector #759 reviewed resident #010's electronic progress notes on Point Click Care (PCC) and identified that RPN #141 had documented that a specified medication was administered to resident #010 despite their medical indicator which was outside of the physician ordered parameters.

During an interview conducted by Inspector #759 with RPN #141, the RPN acknowledged that a medication incident had occurred on the specified date. The RPN further stated that they had decided to administer the specified medication to resident #010 despite of their medical indicator which was outside of the physician ordered parameters.

Inspector #759 conducted an interview with Physician #139, the Inspector reviewed resident #010's physician ordered medication which included the parameters. The Inspector reviewed with the physician the medication incident involving resident #010 on two separate dates. The Physician stated that "They [Physician] would not expect the medication to be administered to the resident due to their [medical indicator] and that the ordered parameters had to be followed".

During an interview conducted by Inspector #759 with the ADOC, the ADOC verified that on two separate dates, the specified medication was administered to resident #010, which was outside of the parameters ordered by the physician. [s. 131. (2)]

Additional Required Actions:

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

Issued on this 22nd day of July, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	LOVIRIZA CALUZA (687), KEARA CRONIN (759)
Inspection No. / No de l’inspection :	2020_679687_0005
Log No. / No de registre :	023376-19
Type of Inspection / Genre d’inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 16, 2020
Licensee / Titulaire de permis :	St. Joseph's Health Centre of Sudbury 1140 South Bay Road, SUDBURY, ON, P3E-0B6
LTC Home / Foyer de SLD :	St. Gabriel's Villa of Sudbury 4690 Municipal Road 15, Chelmsford, ON, P0M-1L0
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Ray Ingriselli

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_671684_0040, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The Licensee must be compliant with r. 131 (2) of the O. Reg 79/10.

The licensee shall prepare, submit and implement a plan in order to be in compliance with LTCHA 2007, r. 131 (2) of the O. Reg 79/10.

The plan shall include but is not limited, to the following:

a) how the licensee will ensure that Registered Practical Nurse #102 and #141 receive re-training on the identified medication, to ensure that medications are administered safely to residents;

b) how the licensee will ensure that all registered staff receive a training on how to navigate their electronic Medication Administration Record (eMAR), specifically the additional directions of the physician's order, and

c) how the licensee will ensure that resident #005 and #010 receive the appropriate medication and correct dosage as prescribed by the physician, specifically ensuring that the physician ordered medical indicator parameter is followed.

The plan must be emailed to the attention of LTCH Inspector Loviriza Caluza at SudburySAO.moh@ontario.ca. The plan is due on July 30, 2020, and the order is to be complied by August 28, 2020.

Please ensure that the submitted written plan does not contain any Personal Information and/or Personal Health Information.

Grounds / Motifs :

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

Compliance Order (CO) #001 was issued to the home in inspection report #2019_671684_0040. The home was ordered to be compliant with subsection 131 (2) of Ontario Regulation 79/10.

Specifically, the home was ordered that they must:

a) Re-educate all registered staff on safe medication administration practices.

b) Educate all registered staff on medical indicator monitoring, focusing on what to do when the medical indicators are not within the therapeutic range.

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While the licensee complied with steps a) through e), non compliance was identified related to medication administration, specific to the medical indicator parameters and medication administration.

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Inspector #759 reviewed resident #005's electronic Medication Administration Record (eMAR) for January 2020, and identified a physician's order. The Inspector further reviewed the eMAR and identified that the specified medication was administered twice when resident #005's medical indicator was outside of the physician ordered parameters.

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January 2018, Section 3, Policy 3-6. The policy stated "All medications administered were listed on the resident's medication administration record (MAR). Each resident received the correct medication in the correct prescribed dosage, at the correct time, and by the correct route. The right resident received the right medication (not expired) of the right dose, at the right time, by the right route for the right reason and completed by the right documentation".

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During an interview conducted by Inspector #759 with the ADOC, the ADOC verified that on two separate dates, the specified medication was administered to resident #010, which was outside of the parameters ordered by the physician.

The decision to re-issue a CO was based on the scope of the identified non-compliance, which was a level 2, indicating the issue was a pattern. The severity

of the issue was a level 2, indicating minimal harm or risk to the residents. The home's compliance history related to the issue was a level 4, indicating a re-issued CO related to the same subsection:

- CO #001 issued December 3, 2019, in inspection report #2019_671684_0040, with a compliance due date of December 31, 2020;

- WN issued December 3, 2019, in inspection report #2019_671684_0040. (759)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Aug 28, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 16th day of July, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Loviriza Caluza

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