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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 19, 2019	2019_605213_0036	018336-19, 018337-19, 018338-19, 018339-19, 018340-19, 018341-19, 018342-19, 018343-19, 018344-19, 018345-19, 018346-19	Follow up

Licensee/Titulaire de permis

Sharon Farms & Enterprises Limited
108 Jensen Road LONDON ON N5V 5A4

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

Earls Court Village
1390 Highbury Avenue North LONDON ON N5Y 0B6

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

RHONDA KUKOLY (213), CASSANDRA ALEKSIC (689)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 27, 28, 29, December 2, 3, 4, 5, 6, 9, 10, 2019.

This follow up inspection was completed related to the following follow-up intakes:

Log #018341-19 related to Compliance Order #001 regarding training and orientation of staff.
Log #018342-19 related to Compliance Order #002 regarding complying with orders and police record checks.
Log #018343-19 related to Compliance Order #003 regarding qualifications of Personal Support Workers.
Log #018339-19 related to Compliance Order #004 regarding 24/7 registered nursing staffing.
Log #018336-19 related to Compliance Order #005 regarding clear direction for oxygen use and advanced care directives.
Log #018337-19 related to Compliance Order #006 regarding staff access to plans of care.
Log #018338-19 related to Compliance Order #007 regarding documentation of care provided.
Log #018340-19 related to Compliance Order #008 regarding investigating, responding and acting.
Log #018346-19 related to Compliance Order #009 regarding reporting critical incidents to the Director.
Log #018344-19 related to Compliance Order #010 regarding medication administration.
Log #018345-19 related to Compliance Order #011 regarding medication incidents.

Critical incident inspection #2019_605213_0037 was also completed concurrently during this inspection, as well as, complaint inspection #2019_778563_0041, which was completed by Inspector #563

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Responsive Health Management Nurse Consultant, the Director of Nursing, the Assistant Director of Nursing, the Manager of Clinical Informatics, the Staff Development Coordinator, Clinical Practice Coordinators, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Residents and family members.

Inspectors also made observations and reviewed health records, internal investigation records, policies and procedures, quality improvement plans, training records, audits, medication incidents, meeting minutes, and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
0 VPC(s)
2 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
LTCHA, 2007 S.O. 2007, c.8 s. 101. (3)	CO #002	2019_736689_0024	213
O.Reg 79/10 s. 107. (3)	CO #009	2019_736689_0024	689
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #008	2019_736689_0024	689

O.Reg 79/10 s. 47.	CO #003	2019_736689_0024	213
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #005	2019_736689_0024	689
LTCHA, 2007 S.O. 2007, c.8 s. 6. (8)	CO #006	2019_736689_0024	213
LTCHA, 2007 S.O. 2007, c.8 s. 6. (9)	CO #007	2019_736689_0024	689
LTCHA, 2007 S.O. 2007, c.8 s. 76. (2)	CO #001	2019_736689_0024	213
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #004	2019_736689_0024	213

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 #010 was served on September 6, 2019 with a compliance date of November 1, 2019. The order stated: The licensee must be compliant with O. Reg.79/10 s.131(2). Specifically, the licensee shall:
a) Ensure that all newly hired registered staff working in the home, including agency staff, receive training related to the medication system prior to performing their duties.
b) A written record is kept of all training related to the medication system, including staff names, dates and training content, to ensure that all new registered staff, including agency staff, received the training.
c) Develop and implement a weekly audit to ensure the timely administration of scheduled medications used in the home. The audit must include who is responsible, audit dates, timelines, corrective actions taken and outcomes of the analysis.
d) A written record is kept of all audit materials.

The binder titled “Late Entry Med Administration Audit Binder (2019)” was reviewed and showed daily print outs of the Point Click Care (PCC) Medication Admin Audit Report, for eleven days, with hand written notes on late medication administration. There were also three different Weekly Medication Auditing Tool forms. The Auditing Tool forms included an analysis that indicated trends seen in resident preference and routine in taking medication at different times and registered staff educated to update care plan with time and location preference. Daily print outs of the Medication Admin Audit Reports for nine days following the first print outs, were all printed on the first date of the inspection. There were no reports printed or analysis for any dates past the two weeks in the binder.

A “Medication Admin Audit Report” was created in Point Click Care for a one-month time period for one resident and showed that the resident received their medications two hours and 32 minutes past the scheduled administration time on one date and two hours and 13 minutes past the scheduled administration time four days later.

The binder labeled Medication Incidents was reviewed and included the following medication incident reports:
- One medication incident report stated for one resident, a medication prescribed for administration two times a day was not sent by pharmacy, medication was not available, unable to administer to resident at one of the prescribed times and none in the stat box. The incident origin was labeled as a pharmacy error and the type was “packaging incident”. Neither the incident nor progress notes for the resident showed any indication that pharmacy was called to obtain the medication or that any actions were taken to

administer the prescribed medications to the resident when they were found to be not available.

- Another medication incident report stated a resident reported that they were worried that their test results would be abnormal as the nurse the evening prior couldn't administer the full dose of medication. The resident received less than a quarter of the dose prescribed as the medication was not available. The incident origin was labeled as nursing and the type was administration incident – wrong dose. Neither the incident report nor the progress notes for the resident showed any indication that pharmacy was called to obtain the medication or that any actions were taken to administer the prescribed medication to the resident when it was found to be not available.

In an interview with a resident, they recalled the incident where they didn't receive their full dose of medication. In an interview with a registered nursing staff member, they recalled the medication incident. The nursing staff said that they did not know why it wasn't available, they didn't call pharmacy or the physician for another order or more medication and did not report it to the next shift. The nursing staff said that the incident occurred again that week, where there was not enough of the same medication for the resident to receive the full dose. The nursing staff said that when it happened again, they called the satellite pharmacy and had them send the medication after hours so the resident could receive the full dose as prescribed.

In an interview with the Director of Care (DOC), they said that if medications were not available to administer as prescribed, the staff were expected to contact the satellite pharmacy and have the medications delivered as soon as possible, and administered the medications as prescribed.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber and failed to comply with Compliance Order #010 when weekly medication administration audits were not completed. [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 O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health and reported to the resident, the resident's substitute decision maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. The licensee also failed to ensure that all incidents and adverse drug reactions were reviewed and analyzed, corrective action taken as necessary and a written record was kept.

Compliance Order #011 was served on September 6, 2019 with a compliance date of November 1, 2019. The order stated: The licensee must be compliant with O. Reg.79/10 s.135(1). Specifically, the licensee shall:
a) Ensure that every medication incident occurring in the home are documented together with a written record of the immediate actions taken to assess and maintain the resident's health, reported to the resident, the resident's substitute decision-maker (as applicable), the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or a registered nurse in the extended class attending the resident and the pharmacy service provider, and kept in the home.
b) Ensure that all registered staff working in the home, including agency staff, receive training related to the process of completing electronic Medication Incident Reports, including a review of the home's policy and procedure "Medication Administration-Medication Incident Index I.D. F-45"
c) Ensure the Nurse Manager(s), Director of Care (DOC), the Acting Director of Care (aDOC) and the Assistant Director of Care (ADOC), or designates, are trained related to their role and responsibilities of medication incidents including documentation, analysis and required actions.
d) Ensure a summary of the medication incident reports are documented and reviewed monthly, as per the medication incident policy titled "Medication Administration-Medication Incident Index I.D. F-45"
e) A written record is kept of all training related to medication incidents as stated above, including staff names, dates and training content, are kept in the home.

The binder titled "Late Entry Med Administration Audit Binder (2019)" was reviewed and

showed daily print outs of the Point Click Care (PCC) Medication Admin Audit Report, for a 16 day period of time with hand written notes on analysis of late medication administration and some follow up. Several medications were noted as having been administered late by two hours. There were no reports for dates past the first two weeks of the 16 day period and therefore no analysis or follow up to any medications identified as administered late following that date.

A “Medication Admin Audit Report” was created in Point Click Care for a one-month time period for one resident and showed that the resident received their medications two hours and 32 minutes past the scheduled administration time on one date and two hours and 13 minutes past the scheduled administration time four days later.

The binder labeled Medication Errors Tracking Trends and Analysis was reviewed. There were no medication incident reports for the medication administration for resident when they received their medication incidents over two ours past the scheduled administration times on two different dates. There were seven Medication Incident Reports for an identified month with two of the seven identified as potential under incident category. One of the incidents identified as potential also stated “resident did not get the 2000 hours medication”, and therefore was an actual incident. In addition, the following incident reports showed:

- A medication incident on an identified date stated that one resident’s medication, that was to be administered two times a day was not sent by pharmacy and there was no medication available. Staff were unable to administer the medication to the resident at a specific time and there was none in the emergency box. The incident origin was labeled as a pharmacy error and the type was “packaging incident”. The medication incident report did not indicate any assessment of the resident to maintain the resident’s health and comfort and did not indicate any actions taken to correct the situation. There was no documentation of analysis of the incident or actions taken to prevent re-occurrence. Record review of the electronic Medication Administration Record (eMAR) for a resident on the identified date showed the medication was not given for two administration times, with a code of “9”, indicating “other/see nurse’s notes” for both administration times. Also, for both of those times, in the spot for pain level, was an “x”. The resident’s progress notes stated: medication not available and none in emergency box, medication reordered. There was no documentation of actions taken other than medication reordered and no documentation of assessment of the resident.
- A medication incident on an identified date stated the resident reported that they were worried that their test results would be high that morning. The resident stated the nurse during the evening prior didn’t have enough medication to give them and gave

resident less than one quarter of the prescribed dose because the medication was not available. The day shift registered nursing staff, to whom this resident reported the incident to, submitted an incident report that day. The nursing staff who did not give the full dose of medication did not complete a medication incident report at the time of the incident. In addition, there was no documentation of assessment of the resident during the evening or night. The registered nursing staff who didn't give the full dose did not contact pharmacy, report the lack of medication administration to the physician or the Director of Nursing and Personal Care or delegate. There was no documentation of analysis of the incident or actions taken to prevent re-occurrence related to the lack of medication supply. Progress notes for the resident said that the full dose of a prescribed medication was not available. No further progress notes were found on the day of the incident regarding assessment of the resident and no progress notes were found on the date after the incident related to the medication incident or assessment of the resident.

In an interview with a registered nursing staff member, they recalled the incident when the resident did not receive their full dose of medication. The nursing staff said that they did not know why it wasn't available, they didn't call pharmacy or the physician for another order or more medication and did not report to the next shift. They said that they did not complete a medication incident form and did not assess the resident. The nursing staff said that the incident occurred again that week, when there was not enough of the same medication for the resident to receive the full dose. The nursing staff said that when it happened again, they called the satellite pharmacy and had them send the medication after hours so the resident could receive the full dose as prescribed.

In an interview with another registered nursing staff, they said that they recalled the morning when the resident informed them that they had not received their full dose of medication the evening prior. They said that they weren't made aware of any medication incident the evening prior and completed an incident report the following morning.

In an interview with the Director of Care (DOC), they agreed that for one of the medication incidents, there was no documentation in either the medication incident report or the resident's progress notes related to assessment of the resident. There was no documentation of follow up to the cause of the lack of medication and no follow up with the staff member related to a lack of documentation. The DOC also agreed that for the other medication incident, the nurse who did not administer the correct amount of medication did not complete a medication incident report, complete any assessment of the resident or take any action related to not having or administering the dose of medication as prescribed. The DOC said there was no documentation of follow up to the

cause of the lack of medication. The DOC also said that there should have been medication incident reports completed for the late administration of over two hours for a resident on two different dates. The DOC also agreed that if there was no medication incident report, the incident would not be included in the monthly or quarterly analysis of medication incidents and therefore could not identify trends or patterns to be able to make improvements needed in systems.

The licensee has failed to ensure that every medication involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health and reported to the resident, the resident's substitute decision maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. The licensee also failed to ensure that all incidents and adverse drug reactions were reviewed and analyzed, corrective action taken as necessary and a written record was kept for medication incidents involving three residents. [s. 135.]

Additional Required Actions:

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

Issued on this 19th day of December, 2019

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) :	RHONDA KUKOLY (213), CASSANDRA ALEKSIC (689)
Inspection No. / No de l'inspection :	2019_605213_0036
Log No. / No de registre :	018336-19, 018337-19, 018338-19, 018339-19, 018340-19, 018341-19, 018342-19, 018343-19, 018344-19, 018345-19, 018346-19
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Dec 19, 2019
Licensee / Titulaire de permis :	Sharon Farms & Enterprises Limited 108 Jensen Road, LONDON, ON, N5V-5A4
LTC Home / Foyer de SLD :	Earls Court Village 1390 Highbury Avenue North, LONDON, ON, N5Y-0B6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rob Bissonnette

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

To Sharon Farms & Enterprises Limited, 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) (a)

Linked to Existing Order / Lien vers ordre existant: 2019_736689_0024, CO #010;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg.79/10 s.131(2). Specifically, the licensee shall:
a) Develop and implement a weekly audit to ensure the administration of scheduled medications as prescribed. The auditor must check for wrong doses, wrong time or late administration, and missed doses including those missed doses due to resident sleeping, not available, away from the home, etc., as part of the audit. The audit must also include who is responsible, the number of residents audited, audit dates, timelines, analysis and corrective actions taken.
b) A written record is kept of all audit materials.

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.

Compliance Order #010 was served on September 6, 2019 with a compliance date of November 1, 2019. The order stated: The licensee must be compliant with O. Reg.79/10 s.131(2). Specifically, the licensee shall:
a) Ensure that all newly hired registered staff working in the home, including agency staff, receive training related to the medication system prior to performing their duties.
b) A written record is kept of all training related to the medication system, including staff names, dates and training content, to ensure that all new registered staff, including agency staff, received the training.
c) Develop and implement a weekly audit to ensure the timely administration of scheduled medications used in the home. The audit must include who is

responsible, audit dates, timelines, corrective actions taken and outcomes of the analysis.
d) A written record is kept of all audit materials.

The binder titled "Late Entry Med Administration Audit Binder (2019)" was reviewed and showed daily print outs of the Point Click Care (PCC) Medication Admin Audit Report, for eleven days, with hand written notes on late medication administration. There were also three different Weekly Medication Auditing Tool forms. The Auditing Tool forms included an analysis that indicated trends seen in resident preference and routine in taking medication at different times and registered staff educated to update care plan with time and location preference. Daily print outs of the Medication Admin Audit Reports for nine days following the first print outs, were all printed on the first date of the inspection. There were no reports printed or analysis for any dates past the two weeks in the binder.

A "Medication Admin Audit Report" was created in Point Click Care for a one-month time period for one resident and showed that the resident received their medications two hours and 32 minutes past the scheduled administration time on one date and two hours and 13 minutes past the scheduled administration time four days later.

The binder labeled Medication Incidents was reviewed and included the following medication incident reports:
- One medication incident report stated for one resident, a medication prescribed for administration two times a day was not sent by pharmacy, medication was not available, unable to administer to resident at one of the prescribed times and none in the stat box. The incident origin was labeled as a pharmacy error and the type was "packaging incident". Neither the incident nor progress notes for the resident showed any indication that pharmacy was called to obtain the medication or that any actions were taken to administer the prescribed medications to the resident when they were found to be not available.
- Another medication incident report stated a resident reported that they were worried that their test results would be abnormal as the nurse the evening prior couldn't administer the full dose of medication. The resident received less than a quarter of the dose prescribed as the medication was not available. The incident origin was labeled as nursing and the type was administration incident – wrong dose. Neither the incident report nor the progress notes for the resident showed

any indication that pharmacy was called to obtain the medication or that any actions were taken to administer the prescribed medication to the resident when it was found to be not available.

In an interview with a resident, they recalled the incident where they didn't receive their full dose of medication. In an interview with a registered nursing staff member, they recalled the medication incident. The nursing staff said that they did not know why it wasn't available, they didn't call pharmacy or the physician for another order or more medication and did not report it to the next shift. The nursing staff said that the incident occurred again that week, where there was not enough of the same medication for the resident to receive the full dose. The nursing staff said that when it happened again, they called the satellite pharmacy and had them send the medication after hours so the resident could receive the full dose as prescribed.

In an interview with the Director of Care (DOC), they said that if medications were not available to administer as prescribed, the staff were expected to contact the satellite pharmacy and have the medications delivered as soon as possible, and administered the medications as prescribed.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber and failed to comply with Compliance Order #010 when weekly medication administration audits were not completed.

The severity of this non-compliance was a level 2 as it was minimal harm to residents and the scope was a pattern as it affected four out of nine residents. The history of this non-compliance is a level 4 as the home has a history of non-compliance in this subsection of the legislation including:
- Compliance Order issued September 6, 2019 in inspection #2019_736689_0024
- Compliance Order issued May 24, 2018 in inspection #2018_722630_0007
- Voluntary Plan of Correction issued April 13, 2017 issued in inspection #2017_736537_0015
(213)

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

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

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 : 002

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

Linked to Existing Order / Lien vers ordre existant: 2019_736689_0024, CO #011;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Order / Ordre :

The licensee must be compliant with O. Reg.79/10 s.135. Specifically, the licensee shall:
a) Ensure that every medication incident occurring in the home is documented together with a written record of the immediate actions taken to assess and maintain the resident's health, reported to the resident, the resident's substitute decision-maker (as applicable), the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or a registered nurse in the extended class attending the resident and the pharmacy service provider, and kept in the home.
b) Ensure that every medication incident occurring in the home is reviewed and analyzed and corrective action is taken as necessary and a written record is kept.
c) Ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacist and any other key staff involved in medication management in the home, meets to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. The evaluation must include:
- A review of Ontario Regulation s. 114 to 137, inclusive.
- A review of drug utilization trends and patterns, including the use of any drug or combination of drugs, including psychotropic drugs that could potentially place residents at risk.
- A review of weekly audit results and analysis of the results.
- A review of medication incidents and adverse drug reactions including patterns and trends identified, with identification of changes needed and/or completed to improve the system in accordance with evidence based practices and if there are none, in accordance with prevailing practices.
d) A written record must be kept of the evaluation, analysis, attendees, dates completed, actions taken, changes made and the date of the next quarterly evaluation.

Grounds / Motifs :

1. The licensee has failed to ensure that every medication involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health and reported to the resident, the resident's substitute decision maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending

physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. The licensee also failed to ensure that all incidents and adverse drug reactions were reviewed and analyzed, corrective action taken as necessary and a written record was kept.

Compliance Order #011 was served on September 6, 2019 with a compliance date of November 1, 2019. The order stated: The licensee must be compliant with O. Reg.79/10 s.135(1). Specifically, the licensee shall:
a) Ensure that every medication incident occurring in the home are documented together with a written record of the immediate actions taken to assess and maintain the resident's health, reported to the resident, the resident's substitute decision-maker (as applicable), the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or a registered nurse in the extended class attending the resident and the pharmacy service provider, and kept in the home.
b) Ensure that all registered staff working in the home, including agency staff, receive training related to the process of completing electronic Medication Incident Reports, including a review of the home's policy and procedure "Medication Administration- Medication Incident Index I.D. F-45"
c) Ensure the Nurse Manager(s), Director of Care (DOC), the Acting Director of Care (aDOC) and the Assistant Director of Care (ADOC), or designates, are trained related to their role and responsibilities of medication incidents including documentation, analysis and required actions.
d) Ensure a summary of the medication incident reports are documented and reviewed monthly, as per the medication incident policy titled "Medication Administration- Medication Incident Index I.D. F-45"
e) A written record is kept of all training related to medication incidents as stated above, including staff names, dates and training content, are kept in the home.

The binder titled "Late Entry Med Administration Audit Binder (2019)" was reviewed and showed daily print outs of the Point Click Care (PCC) Medication Admin Audit Report, for a 16 day period of time with hand written notes on analysis of late medication administration and some follow up. Several medications were noted as having been administered late by two hours. There were no reports for dates past the first two weeks of the 16 day period and therefore no analysis or follow up to any medications identified as administered late following that date.

A "Medication Admin Audit Report" was created in Point Click Care for a one-month time period for one resident and showed that the resident received their medications two hours and 32 minutes past the scheduled administration time on one date and two hours and 13 minutes past the scheduled administration time four days later.

The binder labeled Medication Errors Tracking Trends and Analysis was reviewed. There were no medication incident reports for the medication administration for resident when they received their medication incidents over two ours past the scheduled administration times on two different dates. There were seven Medication Incident Reports for an identified month with two of the seven identified as potential under incident category. One of the incidents identified as potential also stated "resident did not get the 2000 hours medication", and therefore was an actual incident. In addition, the following incident reports showed:

- A medication incident on an identified date stated that one resident's medication, that was to be administered two times a day was not sent by pharmacy and there was no medication available. Staff were unable to administer the medication to the resident at a specific time and there was none in the emergency box. The incident origin was labeled as a pharmacy error and the type was "packaging incident". The medication incident report did not indicate any assessment of the resident to maintain the resident's health and comfort and did not indicate any actions taken to correct the situation. There was no documentation of analysis of the incident or actions taken to prevent re-occurrence. Record review of the electronic Medication Administration Record (eMAR) for a resident on the identified date showed the medication was not given for two administration times, with a code of "9", indicating "other/see nurse's notes" for both administration times. Also, for both of those times, in the spot for pain level, was an "x". The resident's progress notes stated: medication not available and none in emergency box, medication reordered. There was no documentation of actions taken other than medication reordered and no documentation of assessment of the resident.
- A medication incident on an identified date stated the resident reported that they were worried that their test results would be high that morning. The resident stated the nurse during the evening prior didn't have enough medication to give them and gave resident less than one quarter of the prescribed dose because

the medication was not available. The day shift registered nursing staff, to whom this resident reported the incident to, submitted an incident report that day. The nursing staff who did not give the full dose of medication did not complete a medication incident report at the time of the incident. In addition, there was no documentation of assessment of the resident during the evening or night. The registered nursing staff who didn't give the full dose did not contact pharmacy, report the lack of medication administration to the physician or the Director of Nursing and Personal Care or delegate. There was no documentation of analysis of the incident or actions taken to prevent re-occurrence related to the lack of medication supply. Progress notes for the resident said that the full dose of a prescribed medication was not available. No further progress notes were found on the day of the incident regarding assessment of the resident and no progress notes were found on the date after the incident related to the medication incident or assessment of the resident.

In an interview with a registered nursing staff member, they recalled the incident when the resident did not receive their full dose of medication. The nursing staff said that they did not know why it wasn't available, they didn't call pharmacy or the physician for another order or more medication and did not report to the next shift. They said that they did not complete a medication incident form and did not assess the resident. The nursing staff said that the incident occurred again that week, when there was not enough of the same medication for the resident to receive the full dose. The nursing staff said that when it happened again, they called the satellite pharmacy and had them send the medication after hours so the resident could receive the full dose as prescribed.

In an interview with another registered nursing staff, they said that they recalled the morning when the resident informed them that they had not received their full dose of medication the evening prior. They said that they weren't made aware of any medication incident the evening prior and completed an incident report the following morning.

In an interview with the Director of Care (DOC), they agreed that for one of the medication incidents, there was no documentation in either the medication incident report or the resident's progress notes related to assessment of the resident. There was no documentation of follow up to the cause of the lack of medication and no follow up with the staff member related to a lack of

documentation. The DOC also agreed that for the other medication incident, the nurse who did not administer the correct amount of medication did not complete a medication incident report, complete any assessment of the resident or take any action related to not having or administering the dose of medication as prescribed. The DOC said there was no documentation of follow up to the cause of the lack of medication. The DOC also said that there should have been medication incident reports completed for the late administration of over two hours for a resident on two different dates. The DOC also agreed that if there was no medication incident report, the incident would not be included in the monthly or quarterly analysis of medication incidents and therefore could not identify trends or patterns to be able to make improvements needed in systems.

The licensee has failed to ensure that every medication involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health and reported to the resident, the resident's substitute decision maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. The licensee also failed to ensure that all incidents and adverse drug reactions were reviewed and analyzed, corrective action taken as necessary and a written record was kept for medication incidents involving three residents.

The severity of this non-compliance was a level 2 as it was minimal harm to residents and the scope was widespread as it affected four out of five incidents. The history of this non-compliance is a level 4 as the home has a history of non-compliance in this subsection of the legislation including:
- Compliance Order issued September 6, 2019 in inspection #2019_736689_0024
- Compliance Order issued May 24, 2018 in inspection #2018_722630_0007
- Voluntary Plan of Correction issued July 11, 2017 issued in inspection #2017_263524_0015
- Voluntary Plan of Correction issued April 13, 2017 issued in inspection #2017_736537_0015
(213)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 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 19th day of December, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RHONDA KUKOLY

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