Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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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
Sep 6, 2019	2019_716554_0002	004825-18, 008000-18, 003459-19	Critical Incident System

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Bon Air Long Term Care Residence
131 Laidlaw Street South Cannington ON L0E 1E0

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

KELLY BURNS (554)

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): July 29, 30 and July 31; August 01, 02, 07, 08, and August 09, 2019

The following intakes were inspected:
#008000-18 - CIR related to a Public Health declared outbreak
#004825-18 - CIR related to witnessed resident to resident abuse; during the inspection, a second CIR was also inspected related to alleged resident to resident abuse
#003459-19 - CIR related to missing or unaccounted for controlled substance

During this inspection non-compliance was identified related to resident #012 pursuant to LTCHA, 2007, s. 6 (7) plan of care; and similar non-compliance was identified related to resident #001 and resident #012 pursuant to s.24. (1) - immediate reporting. These non-compliance's will be reflected in Inspection Report #2019_716554_0003 as the inspections were completed concurrently.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Workers (PSW), Housekeepers, a Laundry Aide, residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **5 VPC(s)**
- **0 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, protocol, procedure, strategy or system that the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with, specifically related to the medication management system.

In accordance with O. Reg. 79/10, s. 114 and in reference to O. Reg. 79/10, s. 114 (2) the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

Specifically, staff did not comply with the licensee's policy, Narcotics which is part of the licensee's Medication Management System.

The licensee's policy, Narcotics directs the following:
- At shift change two registered nursing staff are to complete a count of all controlled drugs for all residents and document this on the individual narcotic record. Both registered nursing staff completing the count must sign for the number of narcotics on hand. This is completed simultaneously by both registered nursing staff at the commencement of each shift.
- Any discrepancies in either the individual or home narcotic count is to be reported to the DOC or designate immediately.

Related to Log #003459-19:

The Consultant Resident Care and Services submitted a CIR on an identified date

regarding a missing or unaccounted for controlled substance. The incident involved a drug prescribed for resident #021.

The licensee's investigation of the incident was reviewed. The licensee's investigation identified the following:
- On an identified date, the narcotic/controlled substance count was not completed simultaneously by two registered nursing staff. RN #120 indicated counting the controlled substances at an identified hours and indicated that RPN #105 counted thirty minutes later. RPN #105 identified a discrepancy in a prescribed medication for resident #021, noting there was one missing tablet of the drug. The investigation further indicated that the narcotic/controlled substance count on a identified date by RPN #121 and RN #120 had not been completed according to the Narcotics policy.

RPN #105 indicated to Inspector #554 being aware of the identified incident involving the missing or unaccounted for controlled substance. RPN #105 indicated that prior to the incident registered nursing staff were not following the licensee's Narcotic policy regarding shift counts. RPN #105 indicated that registered nursing staff were not completing shift counts together. RPN #105 indicated often the on-coming registered nursing staff took the word of the off-going registered nursing staff that the quantity of drugs remaining in the blister package was accurate and would sign off on the Narcotic and Controlled Drug Administration Shift Count Record.

RN #120 was not available for an interview during this inspection.

Charge Nurse-RN #106 indicated to Inspector #554 being advised of the missing or unaccounted for controlled substance on the identified date. RN #106 indicated awareness that not all registered nursing staff had been following the licensee's Narcotic policy in relation to shift to shift controlled substance counts.

The Administrator indicated to Inspector #554 that there had been a similar incident two months earlier where a controlled substance was missing or unaccounted for.

2. The Director of Care submitted a CIR on identified date regarding a missing or unaccounted for controlled substance. The incident involved a drug prescribed for resident #022.

The licensee's investigation of the incident was reviewed. The licensee's investigation identified the following:

- On an identified date, the narcotic/controlled substance count was completed by RN #122 and RPN #123 and identified a discrepancy in a prescribed medication for resident #022, noting there was one missing tablet of the drug. The investigation indicated that the narcotic/controlled substance count a day earlier by RPN #121 and RN #122 had not been completed according to the Narcotics policy, specifically the count of the controlled substances had not been completed simultaneously by the two registered nursing staff.

RPN #121 and #123, and RN #122 were not available for an interview during this inspection.

Charge Nurse-RN #106 indicated to Inspector #554 being advised of the missing or unaccounted for controlled substance on an identified date. RN #106 indicated awareness that not all registered nursing staff had been following the licensee's Narcotic policy in relation to shift to shift controlled substance counts.

The Administrator indicated to Inspector #554 that the licensee's investigation for the two identified dates identified that registered nursing staff had not followed the licensee's Narcotic policy specifically registered nursing staff had not properly counted controlled substance at the commencement of each shift.

The licensee failed to ensure that the policy related to Narcotics, which is part of the medication management system, was complied with. [s. 8. (1) (b)]

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 ensuring that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, protocol, procedure, strategy or system that the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with, specifically related to the medication management system, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are maintained in safe condition and in a good state of repair.

During this inspection, windows in the dining room were observed opened and not within the legislated requirements pursuant to O. Reg. 79/10, s. 16. While inspecting the non-compliance related to the windows, Personal Support Worker (PSW) #109, Housekeepr (HSK) #110, Registered Practical Nurse (RPN) #105 and Registered Nurse (RN) #106 indicated to Inspector #554 that there was no maintenance staff in the home since an identified date. PSW #109, HSK #110, RPN #105 and RN #106 indicated the maintenance within the home was lacking.

HSK #110 indicated to Inspector #554 that the window latches in an identified area were not latching properly and that the windows were not secure when closed. HSK indicated that the window latches have been broken for at least three months. HSK indicated that the broken window latches were identified on a specific date, documented on the Window Audit form and communicated to the maintenance staff and to the Administrator. HSK #110 indicated this was also documented and communicated to maintenance staff and the Administrator.

The window audit for identified months were reviewed. The document identified that the window latches in the main dining room were identified on specific dates during a two month period as needing repair.

The maintenance binder was reviewed by Inspector #554, the binder contained maintenance request forms for a four week period. As of an identified date, there were twenty-one maintenance requests had not been signed off as repaired or replaced.

The Administrator indicated there had been no maintenance staff working at the long-term care home for approximately four weeks. The Administrator indicated it was the role of the Administrator to oversee Accommodation Services, which included the maintenance of the home. The Administrator indicated in the absence of a maintenance staff the maintenance of the home would be the Administrator's responsibility. The Administrator indicated in the absence of maintenance staff the Administrator reviews the maintenance binder daily and fixes what can be fixed and will contract external service providers as needed for repairs. The Administrator indicated that a very casual maintenance person, from out of town, can be contacted to come when called. The Administrator indicated being aware that some identified maintenance issues had not been repaired and or replaced.

As of an identified date during this inspection, some maintenance items identified above had been signed off as completed, resolved or parts on order and dated for specific dates. The window latches were repaired during this inspection.

The front door entrance/exit door identified on a specific date as not closing tight, and the toilet in an identified resident room remained outstanding.

The licensee has failed to ensure that the home, furnishings and equipment are maintained in safe condition and in a good state of repair, specifically maintenance items identified by staff as needing repair during a four week period. [s. 15. (2) (c)]

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 ensuring he home, furnishings and equipment are maintained in safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that windows in the home cannot be opened more than fifteen centimetres.

On an identified date during this ispection, Inspector #554 observed three slider windows open on the east side of the long-term care home facing the side parking lot. The slider windows were observed to be open (horizontally) the entire length of slider. These windows were observed in identified resident rooms.

Identified resident rooms were observed to have two windows in each of the rooms were the window openings were measured, by Inspector #554, to be 23.5 centimetres (cm). The same was identified in two other resident rooms

PSW #109, HSK #110, RPN #105, and RN #106 indicated to Inspector #554 that they were aware that resident room windows on the identified hall could be open greater than fifteen cm. HSK #110, RPN #105 and RN #106 indicated that the windows in the dining room also opened greater than fifteen cm.

The dining room was observed by Inspector #554 to have four slider windows, two of these windows were observed open during this inspection. The opening of the windows were measured, by Inspector #554, to be forty-eight cm. This dining room is located on an upper floor of the home.

PSW #109, HSK #110, RPN #105 and RN #106 indicated that the concern with the window openings has been brought to the Administrator on more than one occasion. All four staff indicated that the east resident windows had been unsecured since an identified month following the window installations. HSK #110, RPN #109 and RN #106 indicated that the dining room windows had been unsecured for a long time but could not recall a specific date.

HSK #110 provided Inspector #554 with two window audits (Bon Air Window Audit) dated for specific months this year. Both audits identified that the dining room windows were not secured. HSK #110 indicated having completed the audits in the two identified months. HSK indicated that not secured meant could be opened greater than legislation permitted. HSK indicated the window audits had been given to the Administrator during

specific dates.

PSW #109, HSK #110 and RPN #105 indicated that there were residents residing in the long-term care home that exhibited identified responsive behaviour.

The Administrator indicated to Inspector #554 initially not being aware that windows in the long-term care home opened greater than fifteen cm. During a second interview, later that day, the Administrator indicated being aware that the windows opened greater than fifteen cm and directing the maintenance staff to secure the window openings.

At the time of this inspection, staff and the Administrator indicated that there was no maintenance staff employed by the licensee for the home.

All windows in the home were secured during on an identified date during this inspection and could not be opened beyond fifteen cm.

The licensee has failed to ensure that windows in the home could not be opened more than fifteen centimetres. [s. 16.]

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 ensuring windows in the home cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure actions were taken to meet the needs of the resident with responsive behaviours including assessment, reassessment, interventions and documentation of the resident's response to the interventions.

Related to Log #004825-18:

The Director of Care submitted a CIR to the Director on an identified date regarding a witness incident of resident to resident abuse involving resident #001 towards resident #002. The incident occurred the same day. Resident #002 was injured during this incident.

PSW #109, RPN #105, RN #105 and the DOC indicated to Inspector #554 that resident #001 was known to exhibit responsive behaviours towards other residents prior to the incident.

Progress notes were reviewed for resident #001 for a six week period by Inspector #554. The review identified ten other incidents involving resident #001 exhibiting identified responsive behaviours towards other residents prior to the identified CIR incident.

RPN #105 and RN #106 indicated resident #001's responsive behaviours were triggered by specific environmental issues. PSW #109, RPN #105 and RN #106 indicated that resident #001 was not tolerant of resident #002.

The health record for resident #001 fails to provide support that resident was reassessed

or that new interventions were implemented during the identified six week period despite exhibited responsive behaviours specifically towards roommates.

Further review identified that there was no evidence to support that the resident #002 had been reassessed during the identified dates despite exhibited responsive behaviours. There is no evidence to support that interventions were put into place for the safety or well-being of resident #002 and or resident #017 despite exhibited responsive behaviours towards them by resident #001.

RPN #105 and RN #105 confirmed that no reassessments and new interventions had been implemented during the identified dates. Both registered nursing staff indicated that the DOC and the Administrator were aware of resident #001's exhibited responsive behaviours towards roommates.

The DOC indicated to Inspector #554 being aware of that resident #001 exhibited responsive behaviours towards roommates, resident #002 and resident #017. The DOC indicated being aware of triggers for resident #001. The DOC indicated that there had been no reassessment of resident #001 nor new interventions implemented during the identified dates.

The licensee failed to ensure that actions, specifically reassessments, had been taken to meet the needs of a resident #001 who was known to exhibit responsive behaviours towards other residents. [s. 53. (4) (c)]

2. Related to Resident #012:

Non-Compliance was identified while inspecting Log #004825-18, scope was expanded to include resident #012 who was known by nursing staff and the Administrator to exhibit responsive behaviours.

The Director of Care submitted a CIR to the Director on an identified date regarding an allegation of resident to resident abuse involving resident #012 towards resident #018. The incident occurred the same day. The CIR indicated that resident #018 sustained injury.

RPN #103, RPN #105, RN #106 and the DOC indicated to Inspector #554 that resident #012 was known to exhibit identified responsive behaviours, prior to the CIR incident. Registered nursing staff indicated that resident #012's exhibited responsive behaviours

affected other residents residing in the home.

A review of resident #012's care plan by Inspector #554 for an identified review date directed that registered nursing staff were to assess resident #012 for discomfort if exhibiting identified responsive behaviours, and identified specific interventions to be implemented when exhibiting an identified responsive behaviour.

A review of the progress notes for resident #012 for an identified period by Inspector #554. The review documented seven incidents were resident #012 exhibited identified responsive behaviours involving other residents in which staff interventions were ineffective. One incident on an identified date resulted in injury to resident #018.

RPN #105 and the DOC reviewed the plan of care for resident #012 for specific dates and confirmed that no new interventions had been implemented for resident #012.

On an identified date resident #012 was transferred to an acute care facility for assessment. Resident #012 returned to the long-term care home from the acute care facility on an identified date.

The plan of care was reviewed and updated upon resident #012's return to the long-term care home and the interventions were identified.

A further review of progress notes over a three day period following resident #012's readmission to the long-term care home indicated:
Two days post admission – Resident #012 exhibited an identified responsive behaviour towards resident #019 causing injury. Identified monitoring was initiated.
The next day, resident #012's attending physician ordered specific staffing for resident #012. Resident #012 was observed in another resident's room exhibiting the identified responsive behaviour.

RPN #103, RPN #105, RN #106 and RN #117 indicated resident #012's responsive behaviours were triggered by identified environmental issues but indicated that resident #012's responsive behaviours were unpredictable. Registered nursing staff indicated that interventions were of minimal effect or non-effective in diverting resident #012's responsive behaviours.

RPN #105 indicated that resident's attending physician ordered specific to prevent altercations with other residents. RPN #105 indicated that the identified staffing is

inconsistently in place for resident #012 due to staffing shortages in the long-term care home and unavailability of the contracted service provider.

PSW #114, RPN #105 and RN #117 indicated to Inspector #554 that the identified staffing is inconsistent due to staffing shortages with the contracted service provider hired and further indicated there has been times when there is no one to one staffing available for resident #012. RPN #105 and RN #117 indicated that it was difficult to monitor resident #012 while attending to the care needs of the other residents.

The DOC and the Administrator indicated that registered nursing staff are expected to reassess residents when planned interventions have not been effective. The Administrator indicated that physician ordered specific staffing has not been consistent due to unavailability of licensee and the contracted service provider. The Administrator indicated that the inconsistency in the identified staffing had not been discussed with resident #012's attending physician.

RPN #105 indicated that resident #012's exhibited responsive behaviours remain unpredictable and that resident continues to present as a challenge to nursing staff. RPN #105 indicated that resident #012's exhibited responsive behaviours continue to affect other residents.

The licensee failed to ensure actions, specifically reassessment and interventions, were taken to meet the needs of resident #012 who was known to exhibit responsive behaviours. [s. 53. (4) (c)]

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 ensuring actions were taken to meet the needs of the resident with responsive behaviours including assessment, reassessment, interventions and documentation of the resident's response to the interventions, to be implemented voluntarily.

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) 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. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication involving a resident is 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 SDM, 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.

Related to Log #003459-19:

While inspecting Intake #003459-19 related to missing or unaccounted for controlled substance, Inspector #554 reviewed medication incidents for specific dates. The following was identified:

Medication Incident for an identified date:

A Medication Incident Report and Analysis Form, documentation by registered nursing staff, identified that a controlled substance was missing or unaccounted for identified dates. The identified drug was prescribed for resident #023. Documentation on the Medication Incident Report and Analysis Form identifies that the wrong drug was administered to the wrong resident, resident #024 on the identified date.

Documentation fails to account for the missing or unaccounted for controlled substance on the identified date. Documentation fails to identify the immediate actions taken by registered nursing staff to assess or maintain the health of resident #024.

The DOC indicated to Inspector #554 on August 12, 2019 awareness of the medication incident but indicated recall of the incident was vague. The DOC indicated there was no documentation of immediate actions taken on the identified date in relation to the assessment and monitoring of resident #024. The DOC was unable to provide specifics as to how the medication incident was investigated.

Medication Incident for an identified date:

A Medication Incident Report and Analysis Form, documentation by registered nursing staff, identified that a controlled substance was missing or unaccounted for on an identified date. The identified drug was prescribed for resident #021. Documentation on the Medication Incident Report and Analysis Form identifies that the wrong drug was administered to resident #021 on an identified date at the wrong time.

The medication incident form fails to identify the actions taken by registered nursing staff to assess and maintain the health of resident #021 on the identified date and fails to identify that the pharmacy service provider was notified of the medication incident.

The DOC indicated to Inspector #554 awareness of the medication incident. The DOC indicated the medication incident involving the resident was not documented together with a record of the actions taken to assess and maintain the resident's health and indicated that the medication incident does document that the pharmacy service provider was notified.

The Administrator indicated to Inspector #554 that the medication incidents documented on the identified dates were missing details as to actions taken to assess and maintain the resident's health and or the notification of the pharmacy service provider.

The licensee failed to ensure that every medication involving a resident is documented together with a record of the actions taken to assess and maintain the resident's health, and reported to the pharmacy service provider. [s. 135. (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 ensuring that every medication involving a resident is 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 SDM, 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that appropriate actions were taken in response to any medication incident involving a resident.

While inspecting Log #003459-19 related to missing or unaccounted for controlled substance, Inspector #554 reviewed medication incidents for an identified date. The following was identified:

A Medication Incident Report and Analysis Form, documentation by registered nursing staff, identified that a controlled substance was missing or unaccounted for identified dates. The identified drug, was prescribed for resident #023. Documentation on the Medication Incident Report and Analysis Form identifies that the wrong drug was administered to the wrong resident, resident #024 on the identified date. The medication incident report identified that DOC was notified of the incident.

The medication incident form fails to identify the immediate actions taken by registered nursing staff to assess or maintain the health of resident #024 on the identified date.

The health record for resident #024 was reviewed. There was no documentation on the identified dates related to the medication incident involving the resident and or actions taken by registered nursing staff or others related to the incident.

The DOC indicated to Inspector #554 that following a medication incident registered nursing staff are to immediately assess and monitor a resident every shift for twenty-four hours and that the assessment and monitoring are to be documented in the health record.

The DOC and the Administrator indicated to Inspector #554 that there was no documentation of actions taken by registered nursing staff on the identified date in relation to resident #024.

The licensee failed to ensure that appropriate actions were taken in response to a medication incident involving a resident #024. [s. 134. (b)]

Issued on this 13th day of September, 2019

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

Original report signed by the inspector.