Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 21, 2012	2012_179103_0024	O-002361-12	Critical Incident System

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9

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

CARESSANT CARE MARMORA
58 BURSTHALL STREET, P.O. BOX 429, MARMORA, ON, K0K-2M0

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

DARLENE MURPHY (103), JESSICA PATTISON (197)

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): December 18, 19, 2012

Two critical incidents were reviewed during this inspection: Log #O-002361-12 and O-002406-12.

During the course of the inspection, the inspector(s) spoke with Residents, a family member, Health Care Aides, Personal support workers, Registered Practical Nurses (RPN), a Registered Nurse (RN), the Resident Care Coordinator, the Registered Dietitian, the Food Service Supervisor, the Physician, the Medical Advisor, a Pharmacist Consultant, the Regional Manager of Medical Pharmacy, the Director of Care and the Administrator.

During the course of the inspection, the inspector(s) reviewed resident health care records and home policies related to medication administration.

The following Inspection Protocols were used during this inspection:
Medication

Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 9. Doors in a home

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Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9. (1).
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents. O. Reg. 79/10, s. 9. (1).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency. O. Reg. 79/10, s. 9. (1).
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9. (1).

Findings/Faits saillants :

The licensee has failed to comply with O. Reg 79/10 s. 9 (1)(1)(i) whereby a door leading to the outside of the home was found unlocked.

During the afternoon of December 19, 2012 at approximately 1400 hours, writer was able to open both doors to the exit on the North Wing without using keypad. The alarm sounded at the nursing station, but was not responded to by staff for approximately 4.5 minutes. After this time it was turned off, but staff did not appear to check to ensure all residents were present in the home. The key pad to the inside of the two doors was green at the time the writer opened the door despite not having entered the code to exit the door.

Both inspectors observed the North Wing exit while awaiting the staff to respond to the alarm to ensure resident safety. The Director of Care (DOC) was advised of the incident and stated her expectation would be that staff ensured all residents were safe and accounted for when resetting the alarm. In addition, the DOC advised she would contact the door company to ensure it was in full working order. [s. 9. (1) 1. i.]

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

The licensee has failed to comply with O. Reg s. 131 (1) whereby a resident was given a medication not prescribed for the resident.

On an identified date, Resident #2 was given an identified medication in error by the Registered Practical Nurse (RPN) administering medications. The error was detected by the RPN at the time of ingestion. The resident was immediately assessed, and a staff member was assigned to stay with the resident until transported to hospital for further assessment.

The home developed and implemented an action plan to address the medication error. [s. 131. (1)]

Resident #1 was admitted to the home on an identified date. Upon admission, a Registered Practical Nurse (RPN) incorrectly transcribed a medication for this resident from the discharge summary provided by the hospital. This transcription was then double checked by a second RPN in accordance with the home's policy and the error was not detected.

These transcribed orders were then faxed to the physician for approval and then to the pharmacy. Resident #1 received the incorrect medication for a total of eleven doses before the medication error was detected.

The home developed and implemented an action plan including staff education to address this medication error. [s. 131. (1)]

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Issued on this 21st day of December, 2012

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