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

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 6, 2018	2018_654618_0022	020169-18	Resident Quality Inspection

Licensee/Titulaire de permis

Delcare LTC Inc.
4800 Dufferin Street TORONTO ON M3H 5S9

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

Cawthra Gardens
590 Lolita Gardens MISSISSAUGA ON L5A 4N8

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

CECILIA FULTON (618), ADAM DICKEY (643), JOANNA WHITE (727), ORALDEEN BROWN (698)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 7, 8, 9, 10,13, 14, 15, 17, 20, 2018.

The following Critical Incident inspection, Log # 029311-17, related to falls was inspected during this inspection.
The following Complaint intake, Log # 016938-17, related to falls was inspected during this inspection.
The follow Follow up intake, Log # 023780-17 was inspected and complied during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, The Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Housekeeper, Programs Co-ordinator, Family Council chair, Residents' Council chair, Residents and Family members.

During the course of the inspection, the inspectors toured the home, observed resident care, observed staff to resident interaction, observed dining service, observed medication administration, reviewed resident health records, meeting minutes, schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **2 VPC(s)**
- **0 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. 19. (1)	CO #001	2017_547591_0008	618

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The Licensee has failed to ensure that no more than a three-month supply of medication was kept in the home at any time.

This inspection was triggered by a stage one observation of the Medication Cart on an identified home area. During this observation, the inspector identified several bottles of medications that prompted closer observation, due to the size of the bottles and the location which the bottles were being stored within the medication cart.

Interview with Registered Staff #125, revealed that the medications had been supplied by the residents families.

The identified family supplied medications exceeded a three month supply in all cases.

Interview with Registered staff #125 revealed that when families request that the residents receive these family supplied medications, the doctor is notified and writes an order for the medication and the medication is added to the Electronic Medication Record (E-Mar).

Inspector review of the resident's records confirmed that all family supplied medications had been ordered by a physician, transcribed onto the E-Mar, and being administered as ordered.

Interview with the DOC revealed that there is no policy addressing this issue of family supplied medication, but that the expectation is that the medications will be received in their original, unopened container(s) by the registered staff, the physician will be required to order the medication and the order will be transcribed to the E-mar, and the medication kept in the medication cart.

Observation of the medication supply by the DOC verified that the supply of the above mentioned medications supplied by the families, exceeded a three month supply. [s. 124.]

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 to ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time, to be implemented voluntarily.

WN #2: 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 has failed to ensure that every medication incident involving a resident was reported to the resident's Substitute Decision Maker (SDM).

Review of the homes medication incidents occurring in an identified review period, revealed that the home had not notified the SDM of resident #024 when a medication error occurred involving the resident.

As a result of this finding, the sample size was expanded to include two additional residents, resident #022, and #023. Both residents had documented medication errors occurring in the same review period, and neither of the residents SDMs were notified regarding the medication errors.

Interview with the ADOC confirmed that the SDM notification had not occurred for the above mentioned three medication incidents. [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 to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident or the resident's substitute decision-maker., to be implemented voluntarily.

Issued on this 25th day of September, 2018

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

Original report signed by the inspector.