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**

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255


## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 30, 2019 | 2019_587129_0013 | 015175-19 | Critical Incident System |

## Licensee/Titulaire de permis

Maplewood Nursing Home Limited
73 Bidwell Street TILLSONBURG ON N4G 3T8

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

Cedarwood Village
500 Queensway West SIMCOE ON N3Y 4R4

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

PHYLLIS HILTZ-BONTJE (129)

## 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): August 15, 2019.**

**The following intake was inspected: 015175-19 related to the administration of medication.**

**During the course of the inspection, the inspector(s) spoke with Personal Support Worker, Registered Practical Nurse, Registered Nurse, Director of Care and the Administrator.**

**During the course of this inspection the inspector reviewed clinical records, including written plan of care and Medication Administration Records and reviewed the licensee's medication administration policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Medication**

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy or procedures that the policy or procedures were complied with.

In accordance with O. Reg. 79/10, s. 114(2) the licensee is required to ensure that written policies and procedures 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.

The licensee failed to ensure that the licensee's policy and procedures included in the medication management system were complied with.

The Director of Care (DOC) provided the following policies/procedures at the time of this inspection:
a) "Charting-Physician's Orders", identified as #NDM-III-140, dated April 19, 2017, and located in the Nursing Department Manual.
This policy/procedure directed:
-a record of every Physicians' order shall be maintained in the resident's permanent record. Each entry on the physician's order sheet shall be dated and signed by the physician. Where a telephone order is received the nurse records the date, time, order and indicates P.O.(Phone Order) followed by the Physicians' name per the staff's name and including the staff's discipline.

b) "Physician's Orders, Transcription Of", identified as #NDM-lll-142, dated April 19, 2017, and located in the Nursing Department Manual.
This policy/procedure directed:

-In the event of a telephone order from a Physician - the date and time shall be entered on the Doctors Order Sheet, write the order as written, repeat the order to the physician to ensure it is correct and sign the order as follows (Telephone Order from Dr.)

The above noted policy/procedures were not complied with when RN #111 did not document a verbal/telephone order from resident #001's physician.

Resident #001's clinical record indicated that RN #111 wrote a progress note on an identified date, that indicated the resident's condition had changed, the Physician was contacted by telephone and an identified medication was administered to the resident at an identified time following contact with the Physician.

A review of the Doctors Order form indicated that there was not an order for the administration of the above noted medication and a review of the Medication Administration Record (MAR) did not indicate that the identified medication was administered to the resident.

RN #111 was contacted by telephone on an identified date, and during the conversation they indicated they had called the Physician and describe resident #001's condition as well as additional information about the situation. The Physician asked if the home had an identified medication on hand, RN #111 indicated they had the medication and the Physician ordered the resident to receive the identified medication. RN #111 verified that they had not written a verbal/telephone order on the Doctors Order Sheet and they had not documented the administration of the medication on the MAR.

Clinical documentation and RN #111 confirmed that the above noted policies and procedures were not complied with, when a verbal/telephone order from a physician was not documented on the Doctors Order Sheet as was required in the licensee's policy. [s. 8. (1) (b)]

**Issued on this 30th day of August, 2019**

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

**Original report signed by the inspector.**