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
Oct 10, 2013	2013_226192_0011	L-000736-13	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

COLUMBIA FOREST
650 MOUNTAIN MAPLE AVENUE, WATERLOO, ON, N2V-2P7

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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 19, 20, and 23, 2013

This inspection was conducted concurrently with Inspection #2013_226192_0010 and 2013_226192_0012.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Associate Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, support services staff and residents.

During the course of the inspection, the inspector(s) reviewed schedules, medication administration records, narcotic records, medical records, and the staff replacement procedure.

The following Inspection Protocols were used during this inspection:
Sufficient Staffing

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the staffing plan included a back-up plan for nursing and personal care staffing that addresses situations when staff, including registered nurses, cannot come to work.

On August 30, 31, and September 1, 2013 the staff of the home worked without a full complement of nursing staff as defined in the staffing plan and established through interview with the Director of Care. The back-up plan available to the home addresses the call in procedure for the home, but does not provide direction with regard to how to address situations when staff, including registered nurses, cannot come to work.

Review of the schedule, interview with management staff and the person responsible for scheduling confirms that registered staff worked without the full complement of staff identified to be required in the staffing plan, on August 30, 31 and September 1, 2013.

Interview with registered staff of the home identified that a medication error occurred on September 1, 2013, when the home was without a full compliment of registered staff. [s. 31. (3)]

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 the staffing plan includes a back-up plan for nursing and personal care staffing that addresses situations when staff, including registered nurses, cannot come to work, 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 failed to 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.

In September 2013 at 1200 hours resident #001 is documented on the Medication Administration Record (MAR) to have received Tylenol #2 by mouth. The resident's Narcotic and Controlled Drug Count Sheet indicates that the 1200 hour dose of the medication was not provided to the resident, and was wasted.

Interview with a staff member of the home confirms that the medication was not provided to the resident as documented and was wasted. The progress notes do not indicate a reason the resident would not have received their prescribed medication or that the medication had not been given.

A medication incident occurred when resident #001 did not receive their 1200 dose of Tylenol #2 as prescribed in September 2013. The medication incident was not documented. [s. 135. (1) (a)]

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 incident involving a resident and every adverse drug reaction is, documented, together with a record of the immediate actions taken to assess and maintain the resident's health, to be implemented voluntarily.

Issued on this 25th day of October, 2013

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

Debora Saville (192)