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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 20, 2016	2016_226192_0027	022865-16	Critical Incident System

Licensee/Titulaire de permis

EDEN HOUSE CARE FACILITY INC
R.R. #2 GUELPH ON N1H 6H8

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

EDEN HOUSE NURSING HOME
5016 Wellington County Road 29 R. R. #2 GUELPH ON N1H 6H8

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

DEBORA SAVILLE (192)

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 25, 2016

This critical incident inspection was initiated in relation to CIS Report 2777-000003-16 related to a medication error.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Licensee, Registered Nurses, Coroner, Medical Director, Pharmacy Consultant and a Registered Practical Nurse.

The Inspector reviewed medical records, a related letter, schedules, investigation notes, training documents, Pharmacy Quarterly Summary, policy and procedures.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **1 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	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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #001 was prescribed an identified medication.

On a specified date, resident #001sustained a change in condition.

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

Resident #001 was prescribed a specified medication.

The Medication Administration Record (MAR) indicated the dose of the medication followed by the specific amount the resident was to receive.

On a specified date resident #001 did not receive the prescribed dose of the medication.

Interview with Pharmacy Consultant #106 confirmed that while each person administering a medication was responsible to ensure that the correct medication was being given, in the correct dose, the way in which the medication appeared on the Medication Administration Record (MAR) could have contributed to the medication error that occurred with resident #001.

An email from Pharmacy Consultant #106 stated that an older version of Point Click Care was the one that had "dose", rather than the more appropriate "strength" on the MAR and that Eden House had now been converted to the new version, which seemed much clearer.

The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident when the Medication Administration Record failed to clearly identify the prescribed dose of the medication resident #001 was to receive. [s. 6. (1) (c)]

2. The licensee has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

On a specified date resident #001 received a medication, in error, and sustained a change in condition.

A) Interview with Medical Director #107 identified that on the specified date a telephone call was received and they were notified by Registered Nurse(RN) #108 that resident #001 had received a medication error. Orders were left with RN #108. These physician orders, confirmed during interview with RN#108, to have been given as described by MD #107, were not documented within the medical record and were not followed as ordered.

RN #108 stated in an interview that she had not complied with a specified order.

Later on the same date, Medical Director #107 was notified of a change in resident #001's condition and left telephone orders for the resident.

Progress notes identified that one of the ordered treatments was initiated. The record

also indicated that the treatment was stopped and then restarted by a nurse working in the home.

A letter to the home from Medical Director (MD) #107 stated that when the treatment was stopped, the physician was not notified of this change. During interview with MD #107 it was stated that they would have expected nursing staff caring for the resident to problem solve to ensure the resident received the prescribed treatment or would have notified the physician that the prescribed treatment had been stopped. MD #107 stated that had they been made aware they would have considered a revision to the treatment plan.

B) Record review identified that a second treatment ordered for resident #001, was not initiated for 26 hours. Interview with Registered Nurse #109 and MD #107 confirmed that no call was placed to MD #107 to notify the physician that the prescribed treatment could not be completed as ordered.

The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan when resident #001 failed to receive treatments as prescribed and the physician was not notified. [s. 6. (7)]

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 plan of care sets out clear directions to staff and others who provide direct care to the resident and ensuring that care set out in the plan of care is provided as specified in the plan, to be implemented voluntarily.

WN #3: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The licensee's policy for a specified intervention, dated as revised June 2015, included specific procedures for staff to follow when providing the identified procedure.

Review of the medical record for a specified resident identified that an order was documented for a specified intervention. The record indicated that the identified intervention was started however, staff did not follow the specific procedures when implementing the identified intervention.

During interview with the Director of Care (DOC) #101, she stated that if problems were identified when providing the intervention, it would be her expectation that an alternative option would be initiated, the resident reassessed and if problems continued the physician be notified. DOC #101 confirmed that none of these actions were taken by Registered Nurse #110.

Review of specific records on a specified date indicated that documentation was not completed when the identified intervention was initiated.

B) The licensee's policy for an identified intervention identified under Documentation - Resident Record that the progress note related to initiating the treatment were to include required information.

Review of the progress note made by Registered Nurse (RN) #109 failed to identify the required information.

During telephone interview Director of Care (DOC) #101 stated that all of the required information were not included in the note.

C) The licensee's policy titled Resident Medication Error dated as last reviewed January 2013, stated under procedure to notify the "Director of Resident Care"; notify the "resident/Substitute Decision Maker and to document all details of the error on the progress notes, including the report to the physician and SDM, the reaction, treatment and follow-up action".

During interview with Director of Care #101, she stated that it would be her expectation that the Director of Care or designate would be notified at the time of the incident and that the SDM would be notified immediately.

A medication error occurred in the home. The physician was notified immediately following the error. There was no record of when the DOC was notified, however DOC #101 stated she believed the manager on call was notified approximately ten hours after the incident occurred. The record indicated that the SDM was notified eight hours after the incident occurred, by RN #109 who was working the following shift, in spite of a physician order to notify the SDM given to RN #108 when the physician was notified of the error.

The first recorded progress note related to the incident was six hours following the incident by RN #108.

The progress note failed to identify the person making the error, information reported about the error and who it was reported to, the report to the SDM, initial reaction of the resident, or treatment provided through the course of the day shift.

Interview with DOC #101 confirmed that documentation failed to provide a timely record of the activities involving the resident and the effect of the medication error on the resident.

D) The licensee's policy titled Telephone Orders dated as last revised September 2016 and provided by DOC #101 stated under procedure that the receiver of a telephone order was to "document the order immediately on the prescriber order form including the date, time, authorized prescriber's name, receiver's name, status and signature".

Interview with Medical Director #107 stated that on a specified date a call was received by MD #107 reporting a medication error. At this time orders were left with Registered Nurse (RN) #108.

Interview with RN #108 confirmed that she had called the Medical Director to notify them of the medication error and that MD #107 had left orders that were not documented on the prescriber's order form. RN #108 stated that orders received were documented in the progress notes. Review of the progress notes identified that approximately six hours after the incident, a progress note was recorded. RN #108 confirmed that physician orders were to be documented immediately on the order sheet.

DOC #101 stated that it was the expectation that any registered nurse or registered practical nurse receiving a telephone order was to immediately document the order on the order sheet.

The licensee failed to ensure that staff in the home complied with the he licensee's policy for an identified intervention and the, Resident Medication Error and Telephone Order policy. [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that supplies, equipment and devices were readily

available at the home to meet the nursing and personal care needs of residents.

On a specified date, resident #001 received a dose of a prescribed medication that was not the prescribed dose and had the potential to negatively impact their well being.

A) When a change in the residents status was observed, the physician was notified and a treatment ordered. Review of the medical record identified that the treatment was not initiated for more than 26 hours after the physician had ordered it.

The medical record indicated that an appropriate medical device was not available in the home and therefore the treatment was not initiated.

Director of Care #101 stated that the registered staff member was unable to find the appropriate medical device and that when the location of an appropriate device was pointed out to the staff member the treatment was initiated.

The record identified that registered staff on three shifts failed to initiate the treatment.

During interview Medical Director (MD) #107 stated that they would have expected registered staff to have notified them if unable to follow an order and that no staff member had notified them that the medical device was not available. MD #107 indicated that if notified they would have helped to problem solve locating a suitable device.

The licensee failed to ensure that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of residents when a medical device was not available to registered staff responsible for the care of the specified resident.

B) On a specified date the physician ordered a specified treatment for a specified resident. The order was not followed as the RPN did not have the medical device readily available. The order was changed by the physician.

The Director of Care #101 stated that the nurse received an order until the medical device could be obtained.

The licensee failed to ensure that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of residents. [s. 44.]

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 supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents, to be implemented voluntarily.

Issued on this 21st day of October, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBORA SAVILLE (192)
Inspection No. / No de l'inspection :	2016_226192_0027
Log No. / Registre no:	022865-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 20, 2016
Licensee / Titulaire de permis :	EDEN HOUSE CARE FACILITY INC R.R. #2, GUELPH, ON, N1H-6H8
LTC Home / Foyer de SLD :	EDEN HOUSE NURSING HOME 5016 Wellington County Road 29, R. R. #2, GUELPH, ON, N1H-6H8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To EDEN HOUSE CARE FACILITY INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # /
Ordre no : 001

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #001 was prescribed an identified medication.

On a specified date, resident #001 and sustained a change in condition

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 20th day of October, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DEBORA SAVILLE

Service Area Office /
Bureau régional de services : London Service Area Office