**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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## 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 |
|---|---|---|---|
| Dec 13, 2019 | 2019_631210_0026 | 015605-19, 016150-19, 020630-19 | Critical Incident System |

**Licensee/Titulaire de permis**

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON  N2E 4H5

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

Erin Mills Lodge Nursing Home
2132 Dundas Street West MISSISSAUGA ON  L5K 2K7

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

SLAVICA VUCKO (210), IANA MOLOGUINA (763)

## 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): November 22, 25, 26, and 27, 2019.**

**The following Critical Incident System (CIS) report intakes were inspected:**
**- Log #015605-19 and #016150-19, related to missing/unaccounted Controlled Substance and**
**- Log # 020630-19 related to unexpected death.**

**During the course of the inspection, the inspector(s) spoke with the Director of Nursing Care (DONC), Assisstant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Pharmacy Consultants and Personal Support Workers (PSWs).**

**During the course of the inspection the inspectors observed staff to resident interactions, the provision of care, reviewed residents' health records, staff training records, home's investigation notes, and any relevant policies and procedures.**

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

**During the course of this inspection, Non-Compliances were issued.**
**2 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 has failed to ensure that where the Act and Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, the plan was complied with.

In accordance with LTCHA, s. 87 (1), and in reference to O. Reg. 79/10, s. 230 (4) (1) (v) the licensee was required to have an emergency plan in place for dealing with medical emergencies.

A Critical Incident System (CIS) report was submitted to MLTC related to an unexpected death of resident #001 on a specified date and time.

Review of the home's policies "Medical Emergency" #11-01 and "Communication Plan" #01-02 (dated October 22, 2019), which were part of the licensee's Emergency Plan Manual, indicated that the sequence off communication is that the first step is the charge/lead nurse or designate will call 911 to notify the proper service. Second step is the charge/lead nurse to make an in-house announcement to all team members, residents and visitors immediately in the event of a medical emergency. In the policy Medical Emergency the procedure for life threatening medical emergency described that when a person with a life-threatening medical emergency is discovered by a team member they should notify the nearest team member for help, and stay with the person who needs assistance. A team member will call 911 immediately and page for registered staff indicating the building area or room, three times.

A review of resident #001's clinical record indicated that the resident was admitted to the home two days before they passed away. They were of advanced age and had specific directions in regards to their plan of care and treatment in case of life threatening medical

emergency.

Review of resident #001's progress notes revealed that on a specified date and time, on one of the home's units, resident #003 reported to staff that resident #001 was in their room. Staff #111 and #113 responded and discovered that resident #001 was in life threatening medical emergency.

Interview with Staff #111 indicated they initiated a specific medical intervention. Staff #111 delegated Staff #113 to call another staff for help, who was working on another unit. When Staff #114 arrived, they switched then Staff #111 called 911.

During an interview, Staff #113 indicated that Staff #111 started the specific medical intervention right away to resident #001. Then Staff #111 asked them to call Staff #114 for help. At this point, Staff #113 asked another staff to call Staff #114 for help while they gathered the supplies. Staff #113 approximated that it took seven minutes from the time resident #001 required immediate medical intervention to the time Staff #114 arrived on the unit, at which point Staff #111 went to call 911.

During interview, Staff #111 indicated that they were trained in dealing with medical emergency situation every year, and that in a life threatening situation, staff were expected to initiate a specific intervention first. Staff #111 did not delegate Staff #113 to call 911 because they thought staff#113 would not know to give the right information to 911. During the conversation with the inspector, Staff #111 realized and stated that they should have called 911 prior to initiating the intervention on resident #001, or delegated this task to another staff.

During interviews with additional registered staff, Staff #109 and #110 indicated that if they would have found a resident in life threatening situation, they would call 911 first, or delegate it to another staff member at the time when initiating the immediate specific medical intervention.

During an interview, the DONC indicated that if a resident was discovered to be in a medical emergency, the staff were expected to call 911 or delegate it to another staff member, to call 911 prior to or when initiating the immediate specific medical intervention. The DONC acknowledged that the directions in the home's "Medical Emergency" and "Communication Plan" policies were not followed when staff responded to resident #001's medical emergency. [s. 8. (1)]

2. In accordance with O. Reg. 79/10, s. 114 (2) the licensee was required to have developed written policies and protocols 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.

A CIS report was submitted to MLTC reporting that on a specified date, a certain number of a specific narcotic medication were missing for resident # 002, that were supposed to be discontinued and destroyed.

A review of the home’s policy Narcotic and Controlled Substances Administration Record (dated January 17, 2019), indicated that a count of all narcotics should be made on the Narcotic and Controlled Substance Administration Record. A check of the balance-on-hand must be done by two nurses or care providers as per the facility policy at the time of every shift change or as per facility policy. The count and each signature are recorded in the appropriate column on the Narcotic and Controlled Substance Administration Record. Upon completion, the Narcotic and Controlled Substance Administration Record is removed from the binder and kept in the resident’s chart or according to facility procedure. The home’s policy of Discontinued/Expired drugs, Narcotics and Controlled Substances (dated January 17, 2019), indicated drugs that are to be destroyed and disposed of are to be stored safely and securely in a pharmaceutical waste container. Discontinued narcotics and controlled substances are to be removed from the medication cart and the individual Narcotic and Controlled Substance Administration Record signed and dated prior to be placed into the double locked centralized storage within the home.

Interview with Staff #106 indicated they worked on a specified date, when they received a new weekly supply of the specified narcotic medication for resident #002. They removed the previous blister pack from the locked box located in the medication cart. The staff scratched the resident name off the blister pack and threw it in the garbage. They removed the individual Narcotic Administration record (signing sheet) from the Narcotic binder together with the other Narcotic Administration records for other residents. As per Staff #106 they did not notice that there were a certain number of pills left in the blister pack that they discarded accidentally.

Interview with Staff #107 indicated they came to work and were handed the discontinued individual narcotic sheets from the previous staff to file in the residents’ charts as per the current practice in the home. They filed them without checking if the balance was zero; they did not sign them with a second signature, and they did not check the narcotic blister packs to confirm the balance of drugs.

Interview with the DONC indicated they learned about the incident on the following day, and were not able to find the narcotic pills because the garbage was already collected. They indicated that on the specified date, the identified number of narcotic pills left in the medication blister pack together with the signing sheet for resident #002 should have been handed to them for destruction, and if the second staff checked the narcotic blister packs with the individual Narcotic Administration record during the shift exchange and signed the sheet with a second signature, the mistake would have been discovered in a timely manner. Staff #102 acknowledged that the the policy for dealing with narcotics and controlled substances was not followed by two staff. [s. 8. (1) (b)]

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

**Specifically failed to comply with the following:**

**s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:**
**1. The Residents’ Bill of Rights. 2007, c. 8, s. 76. (2).**
**2. The long-term care home’s mission statement. 2007, c. 8, s. 76. (2).**
**3. The long-term care home’s policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).**
**4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).**
**5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).**
**6. The long-term care home’s policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).**
**7. Fire prevention and safety. 2007, c. 8, s. 76. (2).**
**8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).**
**9. Infection prevention and control. 2007, c. 8, s. 76. (2).**
**10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person’s responsibilities. 2007, c. 8, s. 76. (2).**
**11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all staff at the home have received training in medication policies of the licensee, that are relevant to the person's responsibilities.

A CIS report was submitted to MLTC that on a specified date, an identified number of injectable narcotic medications were missing from the stat medication box (emergency box).

Interview with the Pharmacy Quality Improvement Consultant indicated they performed the regular monthly audit of the emergency box on an identified date, and found that an identified number of injectable narcotic medications were not in the emergency box. They were not signed as received in the Drug Administration book on the day when delivered from the pharmacy.

Interview with Staff #106 indicated they worked on the specified date and time on one of the units and the delivery of the weekly medications supply came to their unit. They were asked by the pharmacy courier to receive the bags with medications and sign a paper confirming receipt of them. According to the staff this was a new process for them and they did not know what to do because they were not trained how to do it. They signed the document and the courier left. They were not provided a copy of the signed document. The staff did not check with the courier the number of bags received and the amount indicated on the delivery sheet that they signed. They called the nurse from the other unit to pick up their medications. Staff #106 placed the medications in the medication cart. They did not receive a bag with narcotics for the emergency box. According to Staff #106 since they started working in the home they did not receive training on the process to follow for receiving medications from pharmacy.

Interview with the DONC indicated that the weekly medications and narcotics are usually delivered to one specific unit because there are two registered staff there, and they are trained on how to receive medications from pharmacy. When Staff #102 checked the instructions from the pharmacy to the contracted delivery company, it was not specified which unit the medications should be delivered to.

Interview with Staff #106, #102 and review of the training records indicated that Staff #106 was not trained on the home's process on how to receive medications from pharmacy. [s. 76. (2) 10.]

**Issued on this 16th day of December, 2019**

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

**Original report signed by the inspector.**