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
Oct 5, 2017	2017_448155_0016	019137-17	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No. 8) GP Inc. as general partner of CVH (No. 8) LP
766 Hespeler Road Suite 301 CAMBRIDGE ON N3H 5L8

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

Errinrung Long Term Care Home
67 Bruce Street P.O. Box 7069 THORNBURY ON N0H 2P0

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

SHARON PERRY (155), DOROTHY GINTHER (568), JANETM EVANS (659)

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 21, 22, 23, 24, 25, 28, 29, 30 and 31, 2017.

The following intakes were completed within the RQI:
Log 030814-16 / IL-47197-LO Complaint related to alleged misuse of the long term care home's funding and long term care staff working in retirement home;
Log 002855-17 / IL-49202-LO Complaint regarding care of a resident;
Log 010660-16 / CIS 2513-000003-16 related to alleged resident to resident abuse:
Log 005015-16 / CIS 2513-000001-16 related to an unexpected death of a resident;
Log 029081-16 / CIS 2513-000004-16 related to incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status; and
Log 010222-17 / CIS 2513-000002-17 related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care/Resident Assessment Instrument (RAI) Coordinator, Social Worker, Programs Manager, Maintenance Worker, Registered Dietitian, Resident Services Managers, Housekeeper, Dietary Aide, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Resident Council representative, Family Council representative, residents and families.

The inspectors also toured the home, observed meal service, medication administration, medication storage; reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, posting of required information, investigation notes, medication incidents; observed the provision of resident care, resident- staff interactions, and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **6 WN(s)**
- **6 VPC(s)**
- **0 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 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

During this inspection a resident was observed in a tilt wheelchair which was slightly reclined.

Review of the resident's clinical record did not show evidence of an assessment being completed for the use of the tilt chair. In addition to this, review of the resident's care plan did not show evidence related to the use of the tilt wheelchair.

In interviews completed with two Personal Support Workers and a Registered Nurse (RN), they all shared that the resident used the tilt wheelchair. The RN and Director of Care (DOC) stated that there should be documentation in the resident's care plan related to the use of the tilt wheelchair and they acknowledged that there was no documentation

related to the use of the tilt wheelchair in the resident's plan of care.

The licensee has failed to ensure that the written plan of care set out the planned care for the resident related to the use of the tilt wheelchair. [s. 6. (1) (a)]

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

a) A record review showed that a resident was admitted to the home with multiple diagnoses.

During an interview with a Personal Support Worker (PSW), they shared that during the last couple months they noted a change in the resident's health.
During an interview with another PSW, they shared that they also recalled a change with the resident.
During an interview with a third PSW, they shared that they recalled changes in the resident's health.

During an interview with a Registered Nurse (RN), they shared that the resident had symptoms and required treatments.

During an interview with another Registered Nurse (RN), they shared that the resident had a specific condition. The condition worsened and the resident experienced symptoms for which they received medications and treatments.

During an interview with the Physiotherapist, they shared that they were at the home one day per week. During the last couple of months the resident had symptoms which were increasing. They shared that they documented the changes and symptoms they noted in the progress notes and in assessments so that all other disciplines could see their notes.

Review of the resident's weights for a nine month period showed that their weights were stable. The residents weight for the next three consecutive months showed significant changes each month.

Review of the resident progress notes showed that the Registered Dietitian reviewed the weight warnings on two specific dates and wrote the following:

-Weight warning triggered due to significant weight change. Staff report no significant changes that would cause weight change. Question accuracy of scale. No changes to care plan. Registered Dietitian to monitor when necessary.
-Weight warning continues to be triggered due to significant weight change. Weight fairly stable for one month. No changes to care plan. Registered Dietitian will continue to monitor when necessary.

During an interview with the Registered Dietitian they shared that they were at the home one day a week and during the month they worked their way through the weight report. They shared that they usually look at medications and resident progress notes and usually see the resident. They shared that they were usually more concerned about weight loss. They shared that if they had any conversation with family regarding weight changes it would be documented in progress notes. Review of same showed no documentation.

Review of Minimum Data Set (MDS) assessments for the resident showed, that during a specific month, they had an assessment due to a significant change in status. Three months later, a quarterly review assessment was done. Interview with the Assistant Director of Care/Resident Assessment Instrument Co-ordinator shared that the home did not use the MDS resident assessment protocol (RAP) but used the interdisciplinary care conference to complete the resident MDS assessment. Review of the quarterly interdisciplinary care conference for the identified resident showed that the Food Service Manager completed the dietary section. The nursing section had no information documented and was incomplete in point click care system for both MDS assessments. During an interview with the Assistant Director of Care/Resident Assessment Instrument Co-ordinator they shared that nursing was behind on completing the nursing portion of the interdisciplinary care conferences.

Review of the residents progress notes showed that on an identified date, the physician was contacted and orders were received. The note also stated, can increase a specific medication if specific symptoms are present over the weekend. The reason the order was obtained was the resident was experiencing symptoms. There was no documentation of an assessment of the symptoms done by the nursing staff despite frequent documentation that the resident continued to have a specific symptom. There was no further documentation of the specific symptom until 20 days later, when the Physiotherapist wrote that the symptom was noted today. Fifty-three days later, the specific medication was increased. Fourteen days after the specific medication was increased, it was documented that the resident had a specific symptom, however, there

was no documentation of the assessment/reassessment of the symptom and no documentation of any collaboration with other members of the interdisciplinary team other than a note had been placed in the doctor's book. The next day, it was documented that the resident was experiencing a worsening symptom and the specific medication was increased. Later that day the resident required further medical attention.

The licensee failed to ensure that the staff and others involved in the different aspects of care of the identified resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

b) An identified resident was coded in their June 2017 MDS assessment as not having any pressure ulcers. In their April 2017, MDS assessment they were coded as having a pressure ulcer, a change from their previous MDS assessment done in February 2017, where it was coded that they had no pressure ulcers. Review of the interdisciplinary care conference showed that the nursing section had no information documented and was incomplete in point click care system for both MDS assessments dated April 2017 and June 2017. During an interview with the Assistant Director of Care/Resident Assessment Instrument Co-ordinator they shared that nursing was behind on completing the nursing portion of the interdisciplinary care conferences.

c) An identified resident was coded in their May 2017 MDS assessment as having a pressure ulcer. Record review showed that the identified resident had a pressure ulcer. Review of the May 2017 interdisciplinary care conference showed that the nursing section had no information documented and was incomplete in point click care system.

During an interview with the Director of Care they shared that it was the expectation that the interdisciplinary care conferences were completed by all disciplines. They agreed that it was critical that these interdisciplinary care conferences were completed and documented as this was how all disciplines would have a summary of the resident's status during each quarter.

The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other. [s. 6. (4) (a)]

3. During the review of the medication incidents for a three month period, documentation from the Medication Administration Audit Report showed 57 incidents during this time frame where medications had not been signed as administered by Registered staff.

In interviews with two RPNs they acknowledged that they were aware on occasion that medications had not been signed as administered. During an interview with a RN they shared that registered staff were to sign that medications were administered immediately after the medications were administered.

In an interview with the Director of Care (DOC), they stated that they did not consider it a medication error if staff forgot to sign that medications were administered, rather they just considered it as medication not being signed off as administered. The DOC stated that it was the home's expectation that the staff sign off the medication immediately following administering the medication.

The licensee failed to ensure that the provision of care set out in the plan of care was documented.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm (level 2), the scope was widespread (level 3), and there was no previous non-compliance issued in the last three years (level 1). [s. 6. (9) 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 ensure that there is a written plan of care for each resident that sets out the planned care for the resident; that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #2: 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.

The home's policy "Falls Prevention and Management Program RC-06-04-01", last updated May 2016, under the section titled "Procedures - Interdisciplinary Team" stated that if a resident hit their head or was suspected of hitting their head (i.e. unwitnessed fall) a Clinical Monitoring Record was to be completed.

During a staff interview in stage one of the Resident Quality Inspection it was identified that an identified resident had a fall in the last thirty days. A Post Fall Huddle assessment was done and stated that the resident had a fall. The fall was not witnessed.

During a review of the clinical record there was no documentation that a head injury routine had been completed and there was no completed Clinical Monitoring Record.

The Director of Care (DOC) told inspector #568 that the home had recently transitioned to using the Extendicare policies, but they had not yet transitioned to using all of the Extendicare assessments. Currently they were still using their old head injury assessment tool which was paper based and could be found in the residents' charts. In the case of this fall for the identified resident, the DOC acknowledged that a Head Injury routine had not been completed as per the home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. During a staff interview in stage one of the Resident Quality Inspection it was identified that an identified resident had a fall in the last thirty days. Record review showed that the identified resident had fallen and review of the post falls assessment showed that the fall was not witnessed and that there were no injuries.

The Director of Care shared that a head injury routine was to be done for any unwitnessed fall and for any fall where a resident hit their head.

A Registered Practical Nurse looked in the identified resident's chart and was not able to find the completed head injury form.

The Director of Care shared that they could not find the head injury form for this identified resident. They shared that if the head injury form was completed it should have been on the resident's chart.

3. The most recent Minimum Data Set (MDS) assessment for an identified resident dated June 2017, identified that the resident had a fall in the last thirty days. A Post Fall Huddle assessment stated that the resident had a fall and the fall was not witnessed.

During a review of the clinical record there was no documentation that a head injury routine had been completed and no completed Clinical Monitoring Record. The DOC acknowledged that a head injury routine had not been completed as per the home's policy.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm (level 2), the scope was widespread (level 3), and there was no previous non-compliance issued in the last three years (level 1). [s. 8. (1) (a),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 to ensure that 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, is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

Review of the registered staff schedule for a twenty-five day period was done. The registered staff schedule showed that registered nurses from an agency worked six shifts during this time.

During a review of these registered staff schedules with the Director of Care they shared that these six shifts were worked by three different agency registered nurses who were not an employee of the licensee and a member of the regular nursing staff of the home. The Director of Care also shared that the agency registered nurses were the only Registered Nurses on duty during these shifts and that the Director of Care was available by phone.

The licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm (level 2), the scope was isolated (level 1), and there was no previous non-compliance issued in the last three years (level 1). [s. 8. (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 to ensure that there is at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

A Critical Incident System (CIS) report was submitted to the Director on an identified date for an incident that took place two days earlier. The description of the incident stated that the Director of Care became aware of the incident on a specific date.

During an interview with the Director of Care (DOC) they shared that when they became aware of the incident the home commenced an immediate investigation into the alleged incident of abuse. The DOC acknowledged that they had not reported the alleged incident of abuse to the Director immediately. [s. 24. (1)]

2. Review of progress notes for an identified resident showed that on an identified date, the resident was observed to have altered skin integrity of unknown origin. Four days later, the resident told staff that an identified resident had been involved with the incident. Documentation six days later showed that the resident reported the incident again.

In an interview with the ADOC they stated that they believed this incident to be abusive. In an interview with the Director of Care (DOC) they stated that initially the resident had no explanation for how they got their altered skin integrity but later the resident stated that an incident had occurred with another resident.

Review of the critical incident report (CIS) documented the critical incident occurred on a specific date however the CIS was not submitted until 10 days later.

In an interview with the Director of Care (DOC), they stated that they had been told by their corporate office that once they open the CIS on the system that the Ministry of Health would be able to see the incident and that this would meet the requirement for immediate reporting. The DOC stated they understood the requirement for immediate reporting and acknowledged that for this incident they had not immediately reported their suspicion and the information upon which it was based to the Director.

During this inspection this non-compliance was found to have a severity level of minimum risk (level 1), the scope was pattern (level 2), and there was no previous non-compliance issued in the last three years (level 1). [s. 24. (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 a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that they respond in writing within 10 days of receiving Family Council advise related to concerns or recommendations.

Review of the minutes of the Family Council (FC) meeting held on an identified date, identified concerns of the council.

During an interview with a Family Council representative, they shared that any concerns that were brought forward by the council at a meeting were usually taken to the Director of Care or Administrator for a response. This response was provided by the Social Worker/FC Assistant verbally at the next meeting. The response was then recorded and put in the next meeting minutes.

The Social Worker/ FC Assistant told inspector #568 that concerns raised at a Family Council meeting were documented in the minutes which they would complete following the meeting. A copy of the minutes were given to the Director of Care and Administrator so they could review the concerns brought forward and provide a response. Most often the Social Worker/FC Assistant said that they would provide a response to the concern at the next meeting, one or two months later. This response would be documented in the next set of minutes and posted. The Social Worker/FC Assistant acknowledged that the licensee did not respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

During this inspection this non-compliance was found to have a severity level of minimum risk (level 1), the scope was pattern (level 2), and there was no previous non-compliance issued in the last three years (level 1). [s. 60. (2)]

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 if the Family Council had advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing, to be implemented voluntarily.

WN #6: 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).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Three medication incidents for an identified month were reviewed. A medication incident for a resident showed an error of omission and that two medications were not administered to a resident on two days during the month.

A medication incident for another identified resident showed an error of omission occurred when two medications were not given on one day during the month.

There was no documented evidence of immediate actions taken to assess and maintain the resident's health noted in the resident's clinical record or on the medication incident

report.

In interviews with a Registered Practical Nurse (RPN), they acknowledged that they were aware that medications had not been administered to the residents at the beginning of their shift on the identified date and that no immediate actions were taken to assess and maintain the resident's health. The RPN stated that they reported the medication incidents to the Director of Care (DOC) at the end of their shift.

The DOC acknowledged that immediate actions to assess and maintain the resident's health were not documented for the two residents.

The licensee failed to ensure that every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident's health. [s. 135. (1)]

2. The licensee failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed.

The regulations define a medication incident as "a preventable event associated with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a prescription, and includes,
(a) An act of omission or commission, whether or not it results in harm, injury or death to a resident, or
(b) A near miss event where an incident does not reach a resident but had it done so, harm, injury or death could have resulted.

A review of the Medication Administration Audit Reports for a three month period showed approximately 57 incidents related to medications not being signed off on the Medication Administration Record or Treatment Administration Record. There were no associated medication incident reports related to these medication incidents.

In an interview with the Director of Care, they acknowledged that they did not consider these incidents as medication errors, rather just medications not being signed off. When asked if an investigation was completed with persons who did not sign medications to determine if the medications had been administered the DOC stated no. The DOC stated they use to print off the Medication Administration Audit report and would give the report to the staff and it was their responsibility to go in and sign off medications or provided documentation as to why it was not signed off. The DOC acknowledged they

could not say 100 percent if the medications were administered or not. They shared that they did not receive any incident reports of medications found in the medication strip packages to show they were not administered. The DOC stated that the expectation was that the staff sign off the medication immediately following administering the medication.

A medication incident for an identified resident showed an error of omission occurred when two medications were not administered on an identified date.

Observation of the medication administration record and the medication strip packages for the resident showed that when the two medications were not administered the resident would have had medications in two packages from the medication strip. Strip package number one was documented as administered and strip package two had not been administered and was left in the medication cart. Review of the medication administration record showed that the registered staff had signed that they had administered the medications that were not administered.

The Director of Care (DOC) shared that they had followed up the incident and had been told that the medication was not administered to the identified resident as they had been sleeping. The DOC acknowledged that they were not aware that the resident was administered some of their medications.

The licensee failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm (level 2), the scope was pattern (level 2), and there was no previous non-compliance issued in the last three years (level 1). [s. 135. (2)]

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, documented together with a record of the immediate actions taken to assess and maintain the resident's health; and to ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed, to be implemented voluntarily.

Issued on this 10th day of October, 2017

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

Original report signed by the inspector.