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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 10, 2019	2019_670571_0014	003795-18, 004012-18, 009623-18, 011690-18, 012864-18, 024397-18, 025698-18, 028437-18, 029405-18, 004055-19, 005581-19, 011248-19, 013185-19, 014110-19	Critical Incident System

Licensee/Titulaire de permis

Regional Municipality of Durham
605 Rossland Road East WHITBY ON L1N 6A3

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

Fairview Lodge
632 Dundas Street West P.O. Box 300 WHITBY ON L1N 5S3

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

PATRICIA MATA (571), KELLY BURNS (554)

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 12-15, 19-23 and 26-30, 2019

The following critical incident logs were inspected:
012864-18 related to outbreak;
005581-19, 013185-19, 025698-18, 004055-19 and 011690-18 related to falls;
004012-18 related to medication;
028437-18 related to an allegation of neglect;
003795-18, 009623-18, 0011248-19, 024397-18 and 029405-18 related to allegations of resident to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Care Co-ordinators (RCC), Nurse Practitioner (NP), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers, Occupational Therapist (OT) and Infection Prevention and Control nurse (IPAC).

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
3 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	Légende 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff who provided care to resident #005 related to falls prevention and management.

Related to Log #028437-18:

The Resident Care Co-ordinators (RCC) submitted a Critical Incident Report to the Director on an identified date regarding improper/incompetent treatment of a resident that resulted in harm or risk to resident #005.

The CIR indicated that, RN #101 was called to assess resident #005 on an identified date, who had been involved in an incident. Resident #005 was assessed by RN #101 to have an injury. The resident was transferred to an acute care facility.

The health record for resident #005 was reviewed by Inspector #554 with the following identified:
The kardex posted indicated that resident #005 required a specified level of care and equipment for activities of daily living (ADLs).
The care plan indicated that resident #005 required a different level of care for ADLs.

The licensee’s investigation was reviewed by Inspector #554. The investigation by the licensee or designate identified that the kardex posted for resident #005, indicated a specified level of care requirements during the provision of ADLs. The investigation identified that PSW #120 had provided care as per the Kardex.

In an interview with Inspector #554, PSW #120 indicated recall of the incident involving resident #005. PSW #120 indicated care was provided to resident #005 according to the kardex posted. PSW #120 indicated that RN #101 indicated after the incident that the kardex and the care plan were inconsistent in the care needs of resident #005.

In an interview with Inspector #554, RN #101 indicated being the RN who responded to the incident. RN #101 indicated that PSW #120 had provided care to resident #005 based on the kardex. RN #101 indicated that the kardex is a cue to staff when providing care to a resident. RN #101 indicated that the kardex, for resident #005, indicated a specified level of care was required. The care plan indicated a different level of care was required. RN #101 indicated that the information contained within the kardex and the care plan were to be the same but had not been on the date of the incident. RN #101

indicated that the plan of care for resident #005 on the day of the incident did not provide clear direction to staff.

In an interview with Inspector #554, RCC #105 indicated that the licensee investigated the incident and the outcome of the investigation identified that PSW #120 provided care to resident #005 based on care needs indicated in the kardex. RCC #105 indicated that the care needs identified in the care plan and on the kardex were not the same. RCC #105 indicated that both the kardex and the care plan are a part of the resident's plan of care and both documents should have provided staff with the same information regarding care of the resident.

The licensee failed to ensure that the plan of care for resident #005 set out clear directions to staff and others who were to provide care to the resident. [s. 6. (1) (c)]

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 by ensuring that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, 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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy or protocol, they are complied with.

In accordance with O. Reg. 79/10, s. 114 and in reference to O. Reg. 79/10, s. 114 (2) the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs in the home.

Specifically, staff did not comply with the licensee’s identified policy (#INTERD-03-03-16) (revision date of December 2016) which is part of the licensee’s Medication Management Program and their protocols.

The licensee’s identified policy directs registered staff to monitor a specified medication twice daily for residents who receive the medication. The registered staff are also required to document that the monitoring has been done.

Related to Log #004012-18:

The Manager of Nursing Practice submitted a CIR to the Director on an identified date for an incident related to monitoring of a specified medication. The incident occurred on a specified date involving a specific medication and involved resident #007.

In an interview with Inspector #554, RN #101 and RN #102 indicated being aware of the licensee’s policy for monitoring a specified medication but indicated that the specified medication are to be checked twice per shift by the registered nursing staff assigned to administer medications to residents on each resident home area.

In an interview with Inspector #554, RN #102 indicated being aware of an incident related to the specified medication prescribed to resident #007 on a identified date. The RN indicated being advised of the incident by RPN #103. The RN indicated that the monitoring of the medication had occurred at a specified time that same day.

The licensee’s investigation of the medication incident was reviewed by Inspector #554. Documentation to support that the medication prescribed to resident had been monitored

twice per shift by registered nursing staff on two identified dates could not be found.

In an interview with Inspector #554, RCC #105 indicated that registered nursing staff are to monitor all residents prescribed two specified medications. RCC #105 indicated that the monitoring was to occur twice a shift on all shifts. RCC #105 indicated that the policy states once per shift but that it is the protocol at Fairview Lodge to monitor for the two specified drugs twice per shift.

RN #101, RN #102 and RCC #105 confirmed that the monitoring of the medication for resident #007 did not provide documentation that the monitoring twice per shift had occurred on two identified dates.

2. Related to residents #016, #017 and resident #018:

In an interview with Inspector #554, RN #101, RN #102 and RCC #105 indicated being aware of the licensee’s policy regarding identified medications but indicated that the two specified medications are to be monitored twice per shift by the registered nursing staff assigned to administer medications to residents on each resident home area.

RCC #105 indicated to Inspector #554 that an email communication was sent to all registered nursing staff, by the Manager of Nursing Practice, on an identified date, reminding all registered nursing staff of the correct procedure for monitoring the medication. RCC #105 provided Inspector with the written correspondence, which outlined the procedure for monitoring and documentation of the monitoring for the specified medication

RN #101, RN #102 and RCC #105 indicated that resident #016, resident #017 and resident #018 were all prescribed the specified medication by their physician.

The health record, specifically the physician’s orders, progress notes and electronic medication administration record (eMAR) were reviewed for residents #016, #017 and #018 for an identified period of time.

Resident #016:
Resident #016 was prescribed a specified medication.
The eMAR for an identified month indicated that 19 dates and or 22 occurrences (greater than once per day) lacked documentation that the monitoring had occurred. The eMAR for another identified month lacked documentation that on 11 dates and or 16

occurrences, documentation had occurred.

Resident #017:
Resident #017 was prescribed a specified medication.
The eMAR for an identified month indicated that five dates lacked documentation that the monitoring had occurred. The eMAR for another identified month lacked documentation for monitoring for 5 dates and or 9 occurrences.

Resident #018:
Resident #018 was prescribed a specified medication.
The eMAR for an identified month indicated that 27 dates or 59 occurrences lacked documentation that the monitoring had occurred. The eMAR for another identified month lacked documentation for monitoring for 16 dates and or 33 occurrences.

RCC #105 confirmed with Inspector #554 that they were unable to provide documentation that registered nursing staff had been monitoring specified medication for resident #016, resident #017 and resident #018 according to the licensee's identified policy.

RCC #105 and RCC #127 indicated to Inspector #554 that all registered nursing staff are to follow the licensee's Medication Management Program.

The licensee has failed to ensure that their specified policy and protocols were complied with.

3. Related to Log #014110-19:

The RCC #105 submitted a CIR to the Director on an identified date for an incident involving a medication. The incident according to the CIR occurred on an identified date and involved resident #018.

In accordance with O. Reg. 79/10, s. 114 and in reference to O. Reg. 79/10, s. 135 (2) the licensee shall ensure that all medication incidents are documented, reviewed and analyzed, corrective action taken, and a written record is kept.

Specifically, staff did not comply with the licensee's policy, Medication Incident Management (#MEDI-CL-ONT-022) (effective date August 20, 2018) which is part of the licensee's Medication Management Program.

The licensee's policy, Medication Incident Management directs the following:
Upon discovery of a medication incident, nursing staff are to report the incident to DOC or designate and document the medication incident prior to finishing the shift. Document medication incident in Medication Incident Reporting System (MIRS).
The DOC or designate is to review the incident report within twenty-four hours for standard incidents and immediately for high severity events. DOC or designate is to investigate of the medication incident.
Submit all incident documentation to the pharmacy within three business days.
Notify Medical Director, Pharmacy, SDM, prescriber of the drug and attending physician regarding the incident.

A review of the progress notes for resident #018 was completed by Inspector #554 and identified the following:
On an identified date, documentation by RPN #123 indicated that a medication incident had occurred related to a specified medication for resident #018's.

RPN #123 was not available for an interview during this inspection.

In an interview with Inspector #554, RN #124 indicated being aware of the medication incident for resident #018. RN #124 indicated being advised of the incident by RPN #123 on an identified date. RN #124 indicated that registered nursing staff who discover a medication incident were to complete an on-line medication incident report, document the incident in the progress notes and notify the resident's SDM, the attending physician and the pharmacy of the medication incident.

In an interview with Inspector #554, RCC #105 indicated being aware of the medication incident involving resident #018. RCC #105 indicated that there had been another similar incident for resident #018. RCC #105 indicated that the second incident occurred on an identified date. RCC #105 provided the CIR related to the second incident.

RCC #127 indicated to Inspector #554, that there was no documentation in MIRS for medication incidents that had occurred on the identified dates involving specified medication prescribed for resident #018. RCC #127 indicated that registered nursing staff are to complete a medication incident reporting using the web-based medication incident reporting system.

The licensee has failed to ensure that the Medication Incident Management policy was

complied with. [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 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 policy and protocols, they are complied with, to be implemented voluntarily.

WN #3: 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 a medication incident involving resident #018 was reported to the pharmacy service provider.

Related to Log #014110-19:

RCC #105 submitted a CIR to the Director on an identified date for a medication incident. The incident according to the CIR occurred on an identified date and involved resident #018.

A review of the progress notes for resident #018 was completed by Inspector #554 and identified the following:
On an identified date, documentation by RPN #123 indicated that a medication incident involving resident #018 had occurred. The incident was reported to RN #124 and management.

RPN #123 was not available for an interview during this inspection.

In an interview with Inspector #554, RN #124 indicated being aware of the medication incident involving resident #018. RN #124 indicated being advised of the incident by RPN #123. RN #124 indicated that registered nursing staff who discover a medication incident are to complete an on line medication incident report, document the incident in the progress notes and notify the resident’s SDM, the attending physician and the pharmacy of the medication incident.

In an interview with Inspector #554, RCC #105 indicated being aware of the medication incident involving resident #018. RCC #105 indicated that there had been a similar medication incident involving resident #018. RCC #105 indicated that the second incident occurred on an identified date. RCC #105 provided the CIR related to the second incident.

In an interview with Inspector #554, RCC #127 indicated that there were no documented Medication Incident Reports for the two medication incidents involving resident #018. RCC #127 indicated that the two medication incidents involving resident #018 were not reported to the pharmacy service provider.

The licensee had failed to ensure that a medication incident involving resident #018 was reported to the pharmacy service provider [s. 135. (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 by ensuring that medication incidents are reported to the pharmacy service provider, to be implemented voluntarily.

Issued on this 10th day of September, 2019

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

Original report signed by the inspector.