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 prévue 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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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
Oct 18, 2019	2019_782736_0028	013273-19	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Simcoe
1110 Highway 26 Midhurst ON L9X 1N6

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

Georgian Manor Home for the Aged
101 Thompsons Road PENETANGUISHENE ON L9M 0V3

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

AMANDA BELANGER (736)

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): October 15-16, 2019.

During the course of this Critical Incident inspection, the following intake was inspected:
-one log related to a missing or unaccounted for controlled substance.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Associate Director of Resident Care (ADRC), Registered Practical Nurse(s) (RPNs), Registered Nurse(s) (RNs), Housekeeper(s), and resident(s).

During the course of the inspection, the Inspector conducted a daily tour of the home area, monitored medication administration including the administration of a controlled substance, reviewed resident health records, relevant internal investigation notes, and relevant policies of the licensee.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
2 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 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 medication was administered to the resident as per the prescriber’s directions.

A Critical Incident (CI) report was submitted to the Director related to a missing or unaccounted for controlled substance.

The Inspector reviewed the home's internal investigation notes for the CI report, and noted that a “Letter of Conversation” with Registered Practical Nurse (RPN) #102, indicated they were made aware by the Director of Resident Care (DRC), that they had made multiple medication errors on a specified date.

The Associate Director of Resident Care (ADRC) indicated to the Inspector that resident #003 was the resident involved in the medication errors by RPN #102 on the specified date.

The Inspector reviewed the progress notes for resident #003 and noted that RPN #107 had located the unadministered medications for resident #003 in the medication cart on a specified date, that were to be administered prior to the date the medications were discovered. The progress notes indicated that three of the resident’s medications were not administered as directed, on the specified date.

In an interview with the ADRC, they indicated to the Inspector that based on resident #003’s progress notes, the resident did not receive the medications as per the prescriber’s directions on specified date; and, further indicated that the resident should have received their medications as per the prescriber’s directions. [s. 131. (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 medications are administered to residents as per the prescriber's directions, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

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

a) A CI report was submitted to the Director for missing or unaccounted for controlled substance. The CI report indicated that during the shift count between RPN #102 and RPN #103, it was noted that there was a missing controlled substance for resident #001. The CI report further indicated that RPN #102 was unsure of what had happened to the controlled substance and the missing controlled substance was never located.

In an interview with RPN #102, they indicated to the Inspector that they had worked on the specified date, when it was discovered at shift count that there was an unaccounted for controlled substance for resident #001. The RPN further indicated that they were unaware if the medication incident report had been completed.

The Inspector requested and reviewed the medication incidents for the time period, for the whole home, and was unable to locate a medication incident report related to the unaccounted controlled substance for resident #001.

b) The Inspector reviewed the home's internal investigation notes in relation to the unaccounted for controlled substance and noted that in the "Letter of Conversation" to RPN #102, the DRC indicated that they had made the RPN aware of multiple medication errors that took place.

The Inspector reviewed the home’s internal medication error forms, and was unable to locate any medication error forms from the time period.

The ADRC indicated to the Inspector that resident #003 was involved in the medication errors.

The Inspector reviewed resident #003’s progress notes and noted that three of the resident's medications were not administered to the resident on a specified date.

In separate interviews with RPNs #102 and #103, as well as Registered Nurse (RN) #106, they indicated that any time there was a medication incident, the staff who discovered the error were to fill out the Medication Incident Reporting System (MIRS), which was an online tool used to submit and track medication errors.

In an interview with RPN #103, they indicated to the Inspector that they had worked on the specified date, and completed the narcotic and controlled substances count with RPN #102, and noted that there was an unaccounted tablet of a controlled substance. RPN #103 was unsure if the MIRS had been completed.

A review of the policy titled “Medication Incident Management”, #MEDI-CL-ONT-022, effective October 1, 2018, indicated that the staff member who discovered the medication incident was to report the incident through the MIRS. The policy also provided direction to staff on how to complete the reporting requirement.

In an interview with the ADRC, they indicated to the Inspector that when there was a medication error, the registered staff were to complete a MIRS form to document the medication error and the follow up that had been completed. The ADRC confirmed that both medication omissions and missing or unaccounted for controlled substances were considered medication errors by the home. The ADRC also indicated that they were unable to locate any medication error forms related to the medication errors made by RPN #102 on the specified date. The ADRC further indicated the MIRS was not completed for the errors, and should have been. [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 to ensure that medication incidents involving a resident are documented together with a record of immediate actions to assess and maintain the resident's health, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that CI reports submitted to the Director were updated within 10 days, to include the outcome of the individual or individuals involved.

A CI report was submitted to the Director on a specified date, for a report of the missing or unaccounted for controlled substance. The CI report was amended 26 days later, to indicate that the home had met with the staff member involved, and that the resident had no negative outcomes.

In an interview with the Administrator, they indicated to the Inspector that it was their understanding that CI reports were to be submitted in full within 10 days, and were to include the outcome of the individual(s) involved in the critical incident. Together, the Administrator and Inspector reviewed the CI report related to the missing or unaccounted for controlled substance for resident #001; the Administrator indicated that the CI report was not amended within 10 days to include the outcome of the resident, and it should have been. [s. 107. (4) 3. v.]

Issued on this 18th day of October, 2019

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

Original report signed by the inspector.