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

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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
May 14, 2019	2019_558123_0004	001642-19	Critical Incident System

Licensee/Titulaire de permis

Six Nations of the Grand River
1745 Chiefswood Road P.O. Box 5000 Ohsweken ON N0A 1M0

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

Iroquois Lodge Nursing Home
1755 Chiefswood Road P.O. Box 309 Ohsweken ON N0A 1M0

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

MELODY GRAY (123)

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): April 10, 11 & 12, 2019.

During the course of this inspection the inspector: reviewed residents' records; reviewed the home's records including, policies and procedures; observed medication storage areas and observed medication administration.

During the course of the inspection, the inspector(s) spoke with residents, registered staff, the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, the Staff Educator and the Acting Administrator/ Director of Care (DOC).

A Critical Incident (CI) report log #001642-19 was submitted to the Ministry of Health and Long-Term Care (MOHLTC) reporting a medication incident/adverse drug reaction involving a resident.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **2 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Critical Incident (CI) report #2724-000002-19, submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date in January 2019, regarding a medication incident/adverse drug reaction that altered a resident's health status the previous day, was reviewed. It was noted that at an identified time, on that day, registered staff #104 administered an identified medication to resident #001, a medication not prescribed for them, in error. The physician/Medical Director was notified and gave orders to monitor the resident. The Administrator/Director of Care (DOC) was notified and gave recommendations to monitor the resident. The resident's substitute decision-maker was notified. The resident was monitored for changes throughout the night. The resident was assessed as having a change in their health status and they were effectively treated in the home. No ill effects to the resident were noted as a result of the incident. As a result of the error actions were taken by the home.
The health record of resident #001 was reviewed and it included information as contained in the CI report. Resident #001 was not prescribed the medication which was administered to them on the identified date in January 2019.

Registered staff #104 was interviewed and they reported information as above. They confirmed they administered the identified medication to resident #001 and the medication was not prescribed for the resident. [s. 131. (1)]

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

i. The home's Medication Incident Report and Analysis Forms for the months of January to March 2019, were reviewed. It was noted that on an identified date in March 2019, registered staff #108 self-reported they administered an identified medication, instead of another identified medication to resident #002. Resident #002 was administered the medication at the wrong time as they were prescribed both medications and the medication was not scheduled to be administered until an identified date approximately three months later. The health record of resident #002 was reviewed and contained information as noted in the medication incident report. It was also noted that the medication error report was faxed to the pharmacist and the physician was informed. The physician ordered the date for the next administration of the medication which was administered in error to be changed in order to ensure the resident would receive the next dose at a specified time from the date of the medication error. There was no ill effects to the resident noted.

Registered staff #108 confirmed that on the identified date in March 2019, they did not administer medications to resident #002 in accordance with the directions for use specified by the prescriber as noted above.

ii. The home's Medication Incident Report and Analysis Form of an identified date in February 2019 and health record of resident #003, were reviewed. It was noted that on that date, registered staff #110, identified that resident #003, was not administered a dose of an identified medication as ordered the previous day. The order was changed for the medication to be administered on the day the error was identified.

Registered staff #110 and the Staff Educator were interviewed and reported information as noted in the home's record and the resident's record and they also confirmed that on the identified date in January 2019, the identified medication was not administered to resident #003 in accordance with the directions for use specified by the prescriber. [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 no drug is to be used by or administered to a resident in the home unless the drug has been prescribed for the resident and that drugs are administered to residents in accordance with the directions for use specified by the prescriber, 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).

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 failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker (SDM), if any, the Director of Nursing and Personal Care (DONPC), 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.

i. The home's Medication Incident Report and Analysis Form of an identified date in March 2019 and the health record of resident #002 were reviewed. It was noted that on that date, resident #002 was involved in a medication incident where a medication was not administered to them according to the directions for use specified by the prescriber. The incident was noted to have been reported to the DONPC, the attending physician and to the pharmacy service provider. Resident #002 was noted to have a cognitive status and no SDM was identified in the resident's health record. There was no documentation found in the home's record or the resident's health record indicating the medication incident involving resident #002, was reported to the Medical Director.

The home's Staff Educator was interviewed by the Inspector and they confirmed the medication incident of the identified date in March 2019, involving resident #002 was not reported to the Medical Director.

ii. The home's Medication Incident Report and Analysis Form of an identified date in February 2019, the pharmacy service provider record and the health record of resident #003 were reviewed. It was noted that on that date, resident #003 was involved in a medication incident where a medication was not administered as ordered. The incident was noted to have been reported to the attending physician, the DONPC, and the pharmacy service provider. The incident report noted that the pharmacy service provider was notified but they were not as the pharmacy service provider record did not include documentation of the above incident. The documentation did not include notifying the resident's SDM. No documentation was found to indicate the Medical Director was informed of the incident.

The home's Staff Educator was interviewed by the Inspector and they confirmed the medication incident of the identified date in February 2019, involving resident #003, was not reported to the resident's SDM, the pharmacy service provider and the Medical Director.

iii. The home's Medication Incident Report and Analysis Forms, of identified dates in January, February and March 2019, and the health records of residents #001, #002 and #003 were reviewed. The home's pharmacy service provider's record was also reviewed

and it did not include the medication incidents of January and February 2019.

The Staff Educator was interviewed by the Inspector and they confirmed the home did not follow the medication incident policy and procedure to ensure the incident reports above were fully completed and faxed to the pharmacy as per the policy and procedure. [s. 135. (1)]

2. The licensee failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed and corrective action was taken as necessary.

The home's Medication Incident Report and Analysis Forms, of identified dates in January, February and March 2019, and the health records of residents #001, #002 and #003 were reviewed. The incident analysis section and the corrective action plan sections of the January and February 2019, incident reports were observed to be blank.

The Staff Educator was interviewed by the Inspector and they confirmed the home did not review, analyze and take corrective action as necessary for all medication incidents and adverse drug reactions. [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 reported to the resident, the resident's substitute decision-maker (SDM), if any, the Director of Nursing and Personal Care (DONPC), 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 and to ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed and corrective action is taken as necessary, to be implemented voluntarily.

Issued on this 17th day of May, 2019

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

Original report signed by the inspector.