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 # / Registre no	Type of Inspection / Genre d'inspection
Sep 7, 2016	2016_405189_0009	009013-16	Complaint

Licensee/Titulaire de permis

THE GOVERNING COUNCIL OF THE SALVATION ARMY IN CANADA
2 OVERLEA BLVD TORONTO ON M4H 1P4

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

ISABEL AND ARTHUR MEIGHEN MANOR
155 MILLWOOD ROAD TORONTO ON M4S 1J6

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

NICOLE RANGER (189), JUDITH HART (513), SUSAN LUI (178)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 1, 4, 5, 6, 7, 8, 11, 12, June 23, 2016.

During the course of the inspection, the inspector(s) spoke with Interim Director of Care (IDOC), registered staff, former Assistant Director of Care (ADOC), pharmacist, pharmacy technician.

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	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 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.

Staff interviews and review of resident and home records confirmed that resident #001 received medications which were not documented on the resident's medication administration record (MAR) as per the home's medication policy and protocol.

Review of resident # 001's Physician Order Form revealed a telephone order for an identified medication.

Review of the resident's progress notes revealed that on an identified date, the resident was administered two doses of the identified medication. Review of the resident's electronic medication administration record (eMAR), revealed that the identified medication order and administration of the identified medication was not documented on the eMAR.

Review of the home's Stat Medication Box Tracking form revealed that three doses of the identified medication were removed for the resident's use on two identified dates.

The home's medication policy titled Administering Medications (policy number: 4.07, effective March 1, 2006, Revision January 11, 2016) states that documentation of medication administration must be recorded on the resident's medication administration record (MAR) or eMAR.

Interviews with registered staff #104 and #105 confirmed that administration of medications is to be documented on the resident's eMAR.

Interviews with the home's IDOC confirmed that it is the home's policy that administration of medications is to be documented on the resident's eMAR, and resident #001's medication order and administration of the medication should have been documented on the eMAR. [s. 8. (1) (b)]

2. Review of Physician Order Form revealed an order to increase resident #001's pain medication.

Review of the resident's progress notes and the resident's narcotic/control drug tracking sheets, revealed that beginning at midnight on an identified date, the nursing staff increased the resident's dosage of pain medication every four hours as ordered.

Review of the resident's eMAR revealed that the administration of the identified pain medication every four hours was not documented on the resident's eMAR for a period of five days, as per the home's policy.

Interviews with the home's IDOC confirmed that the order for the increased dosage of the pain medication, should have been documented on the resident's eMAR at that time. Furthermore, the IDOC confirmed that each administration of the pain medication every four hours should have been documented on the resident's eMAR as per the home's Medication Administration policy. [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, 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. (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 all medication incidents and adverse drug reactions are documented, and a written record kept of the review and analysis of the incident and the corrective actions taken.

Correspondence received from resident #001's family member reported that on an identified date, the resident was prescribed and received an identified medication to which the resident was potentially allergic. The family member explained that the resident was prescribed and received an identified medication, which is a sister drug to which the resident was allergic.

Review of the Physician Order Form for resident #001 confirmed that the resident has a documented allergy to a specified medication.

Review of the resident's progress notes confirmed that on an identified date, the resident received two doses of the identified medication. Review of progress notes and interviews with registered staff #104 and #106 revealed that on the morning of an identified date, the home's pharmacy notified registered staff that because the resident was allergic to a specified medication, he/she should not receive an identified medication since it belongs to the same family of drugs as the medication to which the resident was allergic. The drug was discontinued at that time.

Interview with the home's interim Director of Care (IDOC), revealed that this incident would be considered a medication incident and as such, it should have been documented on the home's Medication Incident Report form. The IDOC was unable to locate any Medication Incident Report form documenting the medication incident, analysis of the incident, and corrective actions taken. [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 all medication incidents and adverse drug reactions are documented, and a written record kept of the review and analysis of the incident and the corrective actions taken, to be implemented voluntarily.

Issued on this 12th day of September, 2016

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

Original report signed by the inspector.