Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Aug 26, 2019	2019_729615_0046	014671-19	Complaint

Licensee/Titulaire de permis

Knollcrest Lodge
50 William Street UNKNOWN ON N0K 1M0

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

Knollcrest Lodge
50 William Street MILVERTON ON N0K 1M0

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

HELENE DESABRAIS (615)

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): August 7 and 8, 2019.

The following Complaint was inspected during this inspection:

Complaint IL- 68761-LO/Log #014671-19 related to personal support services and medication.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, the Director of Resident Care, one Pharmacist, two Registered Practical Nurses and one Personal Support Worker.

The inspectors also reviewed clinical records and plan of care for the identified resident, policies and procedures, documentation related to the home's Medication Management and other relevant document.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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 drugs were administered to residents in

accordance with the directions for use specified by the prescriber.

On a specific date, Complaint IL- 68761-LO/Log #014671-19 was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to a resident not receiving their time sensitive medication on time causing them harmful side effects.

A review of the resident's care plan stated, in part, that they would have side effects if the medication was not given on time.

A review of the home's policy #09-05 "Medication Management Principles" dated May 2017, stated in part "The Home recognizes that some grace time for med administration is necessary to accommodate each Resident's individual schedule and choices, and will strive to adhere to the scheduled times as closely as possible."

A review of the home's policy #09-05 "Medication Management Principles" dated May 2017, stated in part "We strive to ensure that our Registered Nurses will have the knowledge, skill and judgement needed to perform medication practices safely as per the College of Nurses of Ontario Practice Standard: Medication. This practice standard applies to all nurses."

A review of the resident physician's ordered scheduled times and administration times of the medication for one month revealed that 27 times the said medication was given one to three hours after the scheduled time.

A review of a second resident physician's ordered scheduled times and administration times of the time sensitive medication for the same month, revealed that 23 times the said medication was given one to three hours after the scheduled time.

A review of a third resident physician's ordered scheduled times and administration times of the time sensitive medication for the same month, revealed that nine times the said medication was given one to three hours after the scheduled time.

During interviews, two Registered Practical Nurses (RPNs) both stated residents' medication should be given on the time scheduled as per the physician's order, if not given on time, the medication "won't work the way they are supposed to". They added that they would not administer medication one to three hours after the scheduled time.

During a telephone interview with a Pharmacist, they stated that it was important that the

said medication be given on time, as the fluctuation in the blood would affect the symptoms and controls the treatment of the disease and that it was not a safe medication practice to not administer the medication on the scheduled time.

During an interview, the Director of Resident Care stated that administering time sensitive medications one to three hours before or after the scheduled time was not right and this could cause the resident to present symptoms of their illness.

During an interview, the Chef Executive Officer stated that the home's expectation was that medication was administered on time and that staff should be documenting the reasons medication were administered late. [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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 26th day of August, 2019

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

Original report signed by the inspector.