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 # / No de registre	Type of Inspection / Genre d'inspection
Dec 15, 2017	2017_491647_0022	028347-17	Critical Incident System

Licensee/Titulaire de permis

2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP
302 Town Centre Blvd. Suite #200 MARKHAM ON L3R 0E8

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

Muskoka Shores Care Community
200 KELLY DRIVE GRAVENHURST ON P1P 1P3

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

JENNIFER BROWN (647)

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): December 11, 12, 2017.

The following critical incident (CI) was inspected during this inspection: 028347-17: related to medication incident/adverse drug reaction

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care, Nurse Practitioner, and Registered Practical nurse.

During the course of the inspection, the inspector conducted observation of care delivery processes including medication administration, review of the home's policies and procedures related to medication administration, and resident health records.

The following Inspection Protocols were used during this inspection: Medication

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 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. 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 are administered to residents in accordance with the directions for use specified by the prescriber.

The home contacted the Long Term Care Home Action line on an identified date and time, and subsequently submitted a critical incident report (CIS), which had indicated that there had been a medication incident.

The CIS indicated that during an audit of the controlled substance book by RN/Acting Director of Care #103, it had been observed that there had been no wastage recorded on the administration line for each of the three administrations for the prescribed identified medication for resident #001. A further record review of the CIS indicated that RPN #102 had administered an incorrect dosage of an identified medication to resident #001 on three occasions during an identified shift on an identified date.

A review of resident #001's clinical record indicated that resident #001 had been identified as requiring an identified care measure on an identified date. At that time, resident #001 was prescribed to receive an identified medication every six hours and the same identified medication every one hour as required (prn).

Record review of the medication administration record indicated that RPN #102 administered the identified medication to resident #001 on three occasions during the identified shift. The amount of identified medication had been documented as ordered.

Record review of the individual monitored medication record indicated the home had been supplied with a standard dose of the identified medication with directions for use every six hours and every one hour as required.

A further record review of the individual monitored medication record indicated that RPN #102 had documented that he/she had administered double doses of the identified medication to resident #001 three times during his/her shift as indicated above.

RPN #102 acknowledged during an interview that he/she gave resident #001 the full supplied amount of the identified medication which had contained two times the prescribed amount on three occasions during his/her identified shift.

RPN #102 had indicated during the interview that he/she had received medication administration education by the home on and identified date, and further acknowledged that the three consecutive medication incidents that involved resident #001 had occurred because care had not been taken to ensure the correct amount was being administered.

Resident #001 had passed away in the home on an identified date.

The Acting Director of Care acknowledged during an interview that RPN #102 had not administered the identified medication to resident #001 as specified by the prescriber. The Acting Director of Care further acknowledged the physician and family of resident #001 had been informed of the above mentioned medication incident and had not voiced any concerns as resident #001 had been in a palliative state prior to the above mentioned medication incidents.

The home was issued a compliance order (CO) under O. Reg. 79/10., s. 131(2) on November 10, 2017, within report 2017_491647_0017 to be in compliance by December 29, 2017. [s. 131. (2)]

Issued on this 15th day of December, 2017

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

Original report signed by the inspector.