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 6, 2017	2017_660218_0011	025602-17	Resident Quality Inspection

Licensee/Titulaire de permis

RETIREMENT HOME SPECIALISTS INCORPORATED
120 Conception Bay Highway Suite 110, Villa Nova Plaza Conception Bay South ON A1W 3A6

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

MORRISTON PARK NURSING HOME
7363 CALFASS ROAD R. R. #2 PUSLINCH ON N0B 2J0

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

APRIL TOLENTINO (218), NUZHAT UDDIN (532)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): November 27-30 and December 1, 2017.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Assistant Director of Care, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses, Personal Support Workers, and residents.

The Inspectors conducted a tour of the home areas, common areas, medication room, and tub rooms. Observations were conducted related to resident care provision, resident/staff interactions, medication administration, medication storage areas, and general maintenance and cleanliness of the home. Inspectors reviewed relevant clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council

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	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. 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 was: (a) documented together with a record of the immediate actions taken to assess and maintain the resident's health, and (b) reported to the resident and their substitute decision maker (SDM), if any, the Medical Director, and the attending physician.

A record review of the home's most recent quarterly review included five medication incidents. The following two incidents were related to missed dosages.

A medication incident report documented that resident #013 received all of their evening medication with the exception of one drug that was packaged in a separate strip pack. The severity of incident was documented as a "close call, incident did not reach resident".

Another medication incident report documented that resident #002 missed a dose of their specified medication. The directions for this drug was to administer tablets to equal a certain number of micrograms. The report documented that there was no harm to the

resident.

The Assistant Director of Care (ADOC) #101 stated that the expectation following a medication error of a missed dosage was for the nurse to immediately assess the resident’s health. ADOC #101 stated that the assessment would be documented in the Progress Notes on PointClickCare (PCC). A clinical record review was conducted and there was no documentation to support that any immediate actions were taken to assess resident #013's and #002's health as a result of not receiving their scheduled medications. ADOC #101 acknowledged that they did not have records to demonstrate that the residents’ were assessed following the incidents.

Furthermore, the ADOC #101 stated that notification to the residents', their families, and to their attending physician would be documented in the Progress Notes on PCC. ADOC #101 also stated that the expectation immediately following the discovery of a medication error was for the nurse to notify the residents’ families and attending physician. ADOC #101 acknowledged that they did not have the documented evidence to support that the residents’ families, the physician, or Medical Director were notified of the above medication incidents.

The licensee failed to ensure that every medication incident involving a resident was documented together with a record of the immediate actions taken to assess and maintain the resident's health and that the medication incidents were reported to the residents' SDM, if any, the Medical Director and the resident's attending physician. [s. 135. (1)]

2. The licensee failed to ensure that every medication incident involving a resident was analyzed with corrective actions taken as necessary and that a written record was kept of these requirements.

Two medication incident reports were further reviewed from the home's last quarterly review, each one separately involving residents #002 and #013. There was no documentation in any of the reports to demonstrate that an analysis was completed for the medication incidents.

The medication incidents involving resident #002 and #013 documented that education was provided as a corrective measure to prevent a recurrence of the incident. There was no documentation to identify the names of the registered staff members that were responsible for the errors. There was also no records to demonstrate that an analysis

was completed for either of the medication incidents.

ADOC #101 acknowledged that the names of the registered staff involved in the incidents were unidentifiable on the reports. ADOC #101 acknowledged that there was a section on the report to state the staff members' names and that they failed to capture this information related to the two incidents.

The ADOC #101 stated that during their Professional Advisory Committee (PAC) meetings, the medication incidents that occurred within the last quarter were reviewed as a whole. ADOC #101 acknowledged that they had no documentation to support that the medication incidents were analyzed. ADOC #101 acknowledged that they did not have a specific process in place related to the analysis and documentation of medication errors during their PAC meetings because they were responsible for other tasks during the meeting.

The licensee failed to ensure that the medication incidents involving resident #002 and 013 were analyzed with corrective actions taken and that a written record was kept of these requirements.

The severity of the issue related to medication incidents was determined to be potential for actual harm and the scope of the issue was determined to be a pattern. The home had a multiple history of unrelated non-compliance. [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 was documented together with a record of the immediate actions taken to assess and maintain the residents' health and that they are reported to the required individuals as per the Long-Term Care Homes Act and Regulations, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's drug destruction and disposal policy include that any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred.

The home's policy titled "Disposal of Discontinued Expired Drugs Narcotics and Controlled substances", last review date completed on January 17, 2017, stated: "Discontinued narcotics and controlled substances are to be removed from the medication cart and the individual narcotic and controlled substances administration record signed and dated prior to being placed into the double locked centralized storage area within the home (i.e. wooden narcotic box). The individual narcotic and controlled substance administration record shall be included with the discontinued card in order to allow reconciliation at the time of destruction".

During an observation of the shift narcotic and controlled substance count, it was discovered that three packs of discontinued controlled substances were stored within the double-locked storage area along with controlled substances that were available for administration.

The Registered Nurse (RN) #108 explained their procedure for counting controlled substances. RN #108 shared that the drugs for destruction and disposal were counted and kept together with the narcotic and controlled substance available for administration. RN #108 stated that the ADOC and RN were both responsible for disposing controlled substances together where they would place the discontinued medications in a separate double-storage area. However, RN #108 stated that when the ADOC was unavailable during evenings and weekends, they would keep the discontinued controlled substances

stored together with the scheduled narcotics until the ADOC became available.

The ADOC #101 acknowledged that they kept their discontinued controlled substances together with the narcotics that were available for administration in the same storage area until destruction and disposal occurred. ADOC #101 acknowledged that their policy related to ensuring that the discontinued narcotics were to be stored separately from the scheduled narcotics was not specified and followed.

The licensee failed to ensure that their drug destruction and disposal policy include that any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurred.

The severity of the issue related to drug destruction and disposal was determined to be potential for actual harm and the scope of the issue was determined to be isolated. The home had a multiple history of unrelated non-compliance. [s. 136. (2) 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 the home's drug destruction and disposal policy include that any controlled substance that was to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occured, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that their program includes a weight monitoring system to measure and record with respect to each resident, their height upon admission and annually thereafter.

Clinical record reviews demonstrated that eight out of twenty residents did not have their heights updated annually.

The Resident Assessment Instrument (RAI) Coordinator #102 and ADOC #101 stated that their process for obtaining residents' heights were completed upon admission only.

The home's Minimum Data Set (MDS) guideline titled, "RAI-MDS 2.0 Canadian Version User's Manual" in section "K2a Height" provided that the process for obtaining heights for current residents was to check the clinical records and if the last record was more than one year ago, the resident's height was to be measured again.

The RAI Coordinator #102 and ADOC #101 acknowledged that they were not following their MDS guidelines for completing residents' heights annually and that their records were a reflection of this practice.

The licensee failed to ensure that residents' heights were obtained on admission and annually thereafter.

The severity of the issue related to height records was determined to be minimum risk and the scope of the issue was determined to be a pattern. The home had a multiple history of unrelated non-compliance. [s. 68. (2) (e) (ii)]

Issued on this 7th day of December, 2017

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

Original report signed by the inspector.