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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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 4, 2017	2017_678680_0022	026411-17	Resident Quality Inspection

Licensee/Titulaire de permis

PEOPLECARE Inc.
28 William Street North P.O. Box 460 Tavistock ON N0B 2R0

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

PEOPLECARE TAVISTOCK
28 William Street North P.O. Box 460 Tavistock ON N0B 2R0

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

TRACY RICHARDSON (680), HELENE DESABRAIS (615), NATALIE MORONEY (610)

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 28, 29, 30 and December 1, 2017.

Critical Incident System (CIS) intake inspected concurrently during the Resident Quality Inspection:
Log #009815-17, CIS #2614-000006-17, related to falls.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Assistant Director of Care, the Director of Food Services, the Director of Environmental Services, the Director of Resident Quality Outcomes, a Pharmacy Technician, Registered Practical Nurses, Registered Nurses, Personal Support Workers, Health Care Aides, Recreation staff, Residents' Council Representative, family members and residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care, and the general maintenance and cleanliness of the home. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed medication administration and drug storage areas, resident and staff interactions, infection prevention and control practices, the posting of Ministry of Health and Long-Term Care Information and inspection reports.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

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 in compliance with and was implemented in accordance with all applicable requirements under the Act.

Ontario Regulation 79/10, s.114 (2) states, "The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home."

Ontario Regulation 79/10, s.135 (1) (b) states, "Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is 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."

During review of medication incidents it was noted that the incidents were not reported to the appropriate people as per regulation.

A review of the home's policy titled "Medication Incident Reporting" reference #011110.00, not dated, stated "Procedure: in the event of a medication-related error or adverse consequence, immediate action is taken, as necessary, to protect the Resident's safety and welfare. The attending physician is notified promptly of any significant incident

or adverse consequence. Hogan Pharmacy: the onsite pharmacy representative or telepharmacist is notified of the incident. The pharmacy representative or telepharmacist documents the error on the Medication Incident Reporting through the risk management portal". There was no mention, in the home's policy that in the event of a medication incident, to report to the resident, the resident's substitute decision-maker, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug and the resident's attending physician.

During an interview, the ED agreed that the home's policy in place was not in compliance with and implemented in accordance with all applicable requirements under the Act and that the home's expectation would be that it should.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act.

The severity of this issue was determined to be a level 1 as there was minimum risk. The scope of the issue was isolated. This area of non-compliance was previously issued on May 26, 2015, as a voluntary plan of correction (VPC) (2015-326569-0010). [s. 8. (1) (a)]

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 in compliance with and is implemented in accordance with all applicable requirements under the Act, 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).

Findings/Faits saillants :

1. The licensee has 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, 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.

A review of the home's medication incidents for a specified time frame indicated there were seven medication incidents that involved residents. According to all medication incident reports, all of the incidents had not been reported to the Medical Director and the DOC, four were not reported to the attending physician or prescriber and three were not reported to the residents' substitute decision-maker.

During an interview, the Executive Director and the ADOC stated that one physician of the home was an attending physician and also the Medical Director of the home, and there was one other attending physician. The Executive Director, ADOC #100 and the Director of Resident Quality Outcomes stated that when a medication incident occurred, the pharmacy, the attending physician and the family were notified. The ADOC said that the Medical Director was made aware of the medication incidents only at the home's quarterly medication review meeting.

During an interview, the ED shared that the medication incidents were not all reported to the resident's SDM, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician. The ED also stated that the home's expectation was that when a medication incident occurred, they would all be notified.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug and the resident's attending physician.

The severity of this issue was determined to be a level 2 as there is minimum harm or potential for actual harm. The scope of the issue was a level 3 as it was widespread. The home has a history of unrelated noncompliance. [s. 135. (1)]

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, 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, to be implemented voluntarily.

Issued on this 4th day of December, 2017

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

Original report signed by the inspector.