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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 8, 2018 | 2018_589641_0013 | 005513-18 | Resident Quality Inspection |

### Licensee/Titulaire de permis

The Corporation of the City of Kingston
216 Ontario Street KINGSTON ON K7L 2Z3

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

Rideaucrest Home
175 Rideau Street KINGSTON ON K7K 3H6

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

CATHI KERR (641), SUSAN DONNAN (531)

### Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): April 9, 10, 11, 13 and 16, 2018.**

**Log #007370-18 related to a respiratory outbreak was inspected in conjunction with this inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the RAI Coordinator, Registered Dietitian, Resident Council president, family members, and residents.**

**During the course of the inspection, the inspectors conducted a tour of the home, observed medication administration and written processes for handling of medication incidents and adverse drug reactions, reviewed resident health care records, observed and reviewed infection control practices, reviewed Resident Council minutes, the home's staffing schedules for the nursing department, and the licensee's policies related to falls prevention, medication management and outbreak protocols.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Nutrition and Hydration**
**Residents' Council**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 medications were given to residents #022, #014 and #024 in accordance with directions for use specified by the prescriber.

The home's medication incidents were reviewed for a specified four month period. Three medication incidents were inspected.

The first incident reviewed was MEDINC22675 which was categorized by the home as a C. This category indicated that the medication incident reached resident #022 but did not cause harm to the resident. Resident #022 had a physician's order for a specified medication. Medication incident #MEDINC22675 indicated that on a specified date, resident #022 did not receive the medication as prescribed. The incident documentation noted that the registered nursing staff had signed that the medication had been given but had not taken the medication out of the blister pack.

The second incident reviewed was MEDINC23297 which was categorized by the home as a C. This category indicated that the medication incident reached resident #014 but did not cause harm to the resident. Resident #014 had a physician's order to receive a specified medication. Medication incident #MEDINC23297 indicated that on a specified date, it was noted that resident #014 did not get the medication as prescribed.

The third incident reviewed was MEDINC25566 which was categorized by the home as a C. This category indicated that the medication incident reached resident #024 but did not cause harm to the resident. Resident #024 had a physician's order to receive a specified medication once daily. Medication incident #MEDINC25566 indicated that on a specified date, resident #024 was given the specified medication at two separate times during that day therefore not receiving the medication as prescribed.

During an interview with Inspector #641 on April 16, 2018, the Director of Care, (DOC) indicated that medication incidents were documented online by the registered nursing staff and a copy of these would come to the DOC. The DOC indicated that medications were not administered to resident #022, #014 and #024 in accordance with the directions for use specified by the prescriber, as reported in the incidents.

The licensee failed to ensure that medications were administered to residents #022, #014 and #024 in accordance with directions for use specified by the prescriber. [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.***

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**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. (3) Every licensee shall ensure that,**
**(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).**
**(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).**
**(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the quarterly review of all medication incidents and adverse drug reactions that have occurred in the home since the last review, included any changes and improvements identified in the review, how they were implemented and a written record was kept identifying this.

The home's medication incidents were reviewed for a specified four month period. Inspector #641 reviewed the minutes of the licensee's last two Professional Advisory Committee (PAC) meetings. In both meetings there was a note indicating that Medical Pharmacies reviewed the medication incidents. There were no other references to medication incidents in the minutes of these two meetings. The Inspector also reviewed Medical pharmacies medication incident tracking tool for a specified two month period. There was no reference on the tool as to when this was reviewed and any changes or improvements that were identified in the review and if they had been implemented.

During an interview with Inspector #641 on April 13, 2018, the Director of Care (DOC) indicated that the home reviews all of the medication incidents during the Professional Advisory Committee (PAC) meetings that were held quarterly. The DOC indicated that the pharmacy consultant for the home compiles the medication incidents and the committee discusses the trends that have occurred during the last quarter. The DOC indicated that this was done verbally and there was no written documentation specifying if the home had made any changes or improvements that had been identified in the review or if they had been implemented.

The licensee failed to ensure that a written record was kept of any changes and improvements identified in the quarterly review of the medication incidents and if they had been implemented. [s. 135. (3)]

**Issued on this 1st day of June, 2018**

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

**Original report signed by the inspector.**