Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Mar 3, 2020	2020_644507_0006	020711-19, 021598-19, 021894-19, 022749-19, 001065-20	Critical Incident System

Licensee/Titulaire de permis

North York General Hospital
4001 Leslie Street NORTH YORK ON M2K 1E1

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

Seniors' Health Centre
2 Buchan Court NORTH YORK ON M2J 5A3

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

STELLA NG (507)

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): February 18, 19, 20, 21, 24 and 25, 2020.

The following intakes were inspected during this inspection:
Logs #020711-19 and 001065-20 related to written complaint received regarding provision of care, log #021589-19 related to medication incident, log #021894-19 related to plan of care, and log #022749-19 related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Directors of Care (ADOC), Nurse Practitioner (NP), Registered Practical Nurses (RPN) and Personal Support Workers (PSW).

During the course of the inspection, the inspector observed staff to resident interactions, resident to resident interactions, and the provision of care, reviewed resident health records and home records, and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **5 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

A Critical Incident System (CIS) report was submitted to the Director regarding the provision of care to resident #002.

Review of the CIS report and the home's investigation notes indicated that on an identified date, at an approximate time, resident #002's substitute decision-maker (SDM) provided care to the resident with a staff member, and asked staff #112 to provide the same care to the resident in one to one and a half hours' time prior to leaving the facility. Resident #002's SDM returned to the facility approximately two hours later, and observed the resident had not been provided the specific care since they left. Resident #002's SDM expressed the concerns to the home the next day.

Review of the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) for resident #002 indicated that the resident required two staff members to provide the specific care. Review of the written plan of care for resident #002 indicated that staff were to follow the instructions on the wall above the head of the bed.

Review of the home's complaint record indicated that the home conducted an investigation on the above mentioned concern from resident #002's SDM. As a result of the investigation, staff #112 was disciplined for not following resident #002's plan of care; specifically, did not provide the specific care on the above mentioned identified date.

In an interview, staff #112 stated that on the identified date, at an approximate time, resident #002's SDM asked them to provide the specific care to resident #002 about one hour later before leaving the facility. At approximately one hour later, staff#112 observed resident #002 was in the same position as the instruction on the wall indicated. Staff #112 was confused by the request made by resident #002's SDM earlier. Staff #112 did not provide the specific care to the resident.

In interviews, staff #109 and #113 acknowledged staff #112 did not provide care to resident #002 as specified in the plan of care on the above mentioned date. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 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, was complied with.

In accordance to O.Reg.79/10, s.114 (2), The licensee shall ensure that written polices 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.

The home uses North York General Hospital Pharmacy and North York General Hospital Policy: Long-Term Care for their medication management system. The staff did not comply with the licensee's policy titled, Medication Pass & Administration, policy #:III-9, with a revised date of October 2019. Under medication pass number 13, it indicated that registered staff to ensure all medications have been taken by the resident and sign off administration on electronic Medication Administration Record (eMAR) immediately.

A) CIS report was submitted to the Director in regards to a medication incident which involved resident #003.

Review of the progress notes of resident #003 indicated that on an identified date, staff #105 documented that the resident was given three different morning medications (medication A, B and C) at an identified time by mouth. Review of the eMAR of resident #003 for the month did not indicate the administration of medication A at the identified time on the identified date.

In an interview, staff #105 stated that the administration of medication A by mouth was documented in the progress notes, but not in the eMAR as required.

B) Another CIS report was submitted to the Director in regards to an incident which involved resident #004.

Review of the health record of resident #004 indicated that the resident exhibited responsive behaviours at times. Review of the eMAR for two identified months indicated that the resident was prescribed an identified medication by mouth as needed (PRN) for up to two times per day, to be used before behaviour escalates.

Review of the progress notes of resident #004 indicated the above mentioned identified medication by mouth PRN was administered on two identified dates. Review of the eMAR for the two identified months did not indicate the administration of the identified medication PRN for those two identified dates.

In interviews, staff #104 and #110 acknowledged the administration of the identified medication by mouth PRN on the two identified dates was not signed off in the eMAR as required. [s. 8. (1) (b)]

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 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, is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response that complied with paragraph 3 provided within 10 business days of the receipt of the complaint from resident #001's substitute decision-maker (SDM) was provided to resident #001's SDM.

On an identified date, the home received a written complaint from resident #001's SDM regarding the provision of care to the resident. The home reported receiving the written complaint to the Director on the same day.

Record review of the home's record and interview with staff #109 indicated that the home conducted an investigation upon the receipt of the written complaint from resident #001's SDM, and an email was sent to resident #001's SDM informing them of the outcome of the investigation and the actions the home took in regards to their complaint 20 business days later.

In an interview, staff #109 acknowledged the home responded to resident #001's SDM 20 business days after having received the written complainant. [s. 101. (1) 1.]

2. The licensee has failed to ensure that: (a) the documented record (of complaints received) was reviewed and analyzed for trends, at least quarterly, (b) the results of the review and analysis were taken into account in determining what improvements were required in the home, and (c) a written record was kept of each review and of the improvements made in response.

CIS report was submitted to the Director regarding the receipt of a written complaint from resident #001's SDM.

During the on-site inspection, the home was unable to provide the inspector with the written record of the results of the quarterly reviews and analysis for trends of complaints received, and improvements required.

In interviews, staff #109 and #113 acknowledged the quarterly review and analysis of the complaints received was not conducted. [s. 101. (3)]

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: (a) the documented record (of complaints received) is reviewed and analyzed for trends, at least quarterly, (b) the results of the review and analysis are taken into account in determining what improvements are required in the home, and (c) a written record is kept of each review and of the improvements made in response, to be implemented voluntarily.

WN #4: 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 resident #003 in accordance with the directions for use specified by the prescriber.

CIS report was submitted to the Director on an identified date in regards to a medication incident which involved resident #003.

Review of the CIS and resident #003's health record indicated that the resident was scheduled for an identified treatment on an identified date.

Review of the progress notes and physician's order of resident #003 indicated the following:
- Two days prior to the treatment, upon return to the home from the pre-treatment appointment at the hospital, resident #003's family member gave the nursing staff instructions from the hospital. The instruction indicated that on the morning of the treatment, resident #003 may only take three medications (medication A, B and C) from their morning medications.

- The day prior to the treatment, staff #107 wrote on the physician order, indicated to hold all morning medications, except medication A, B and C.
- On the day of the treatment, staff #105 documented that the resident was given morning medications of medication A, B and C in the morning before the treatment.

Review of the eMAR of resident #003 for the identified month indicated that the resident's morning medications did not include medication A.

In an interview, staff #105 stated that resident #003 was scheduled for the identified treatment on an identified date, and the resident's family member was scheduled to pick up the resident at an identified time. Staff #105 administered medications A, B and C to the resident 10 minutes prior to the pick up, according to the instructions from the hospital. Staff #105 stated that they did not check the eMAR prior to the medication administration. After the medication administration, staff #105 went to sign off on the eMAR and realized there was no space to sign off for the morning dose of medication A. Staff #105 returned to work at a later shift on the same day and discovered resident #003 received medication A twice that day instead of once daily as indicated on the doctor's order and eMAR. Resident #003 was sent to the hospital for observation during the night, and returned to the home a few hours later with no new directions.

In an interview, staff #107 stated that when they transcribed the instruction from the doctor from the hospital in regards to the morning medications to be taken on the treatment day, they did not realize medication A was prescribed to be taken once daily at bedtime. Staff #107 also stated that all medications prescribed by doctors outside the home are considered recommendations, they only become orders when the home physician, NP, or the registered staff (after confirming the medications with the doctor) transcribed the medications onto the physician's order. Registered staff should check the physician's order and eMAR prior to medication administration.

In interviews, staff #105 and #107 acknowledged medication A by mouth was administered to resident #003 not in accordance with the directions for use specified by the prescriber on the morning of their treatment. [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.

WN #5: 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 has failed to ensure that, (a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, (b) any changes and improvements identified in the review were implemented, and (c) a written record was kept of everything provided for in clause (a) and (b).

CIS report was submitted to the Director regarding a medication incident which involved resident #003.

During the on-site inspection, the home was unable to provide the inspector with the written record of the results of the quarterly reviews and analysis of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

In interviews, staff #110 and #113 acknowledged the quarterly review and analysis of all medication incidents and adverse drug reactions was not conducted. [s. 135. (3)]

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, (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, (b) any changes and improvements identified in the review are implemented, and (c) a written record is kept of everything provided for in clause (a) and (b), to be implemented voluntarily.

Issued on this 4th day of March, 2020

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

Original report signed by the inspector.