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 prévue 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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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 25, 2019	2019_615609_0012	004826-19	Critical Incident System

Licensee/Titulaire de permis

Smooth Rock Falls Hospital
107 Kelly Road P.O. Box 219 SMOOTH ROCK FALLS ON P0L 2B0

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

Smooth Rock Falls Hospital
107 Kelly Road P.O. Box 219 SMOOTH ROCK FALLS ON P0L 2B0

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

CHAD CAMPS (609)

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): March 18-20, 2019.

This inspection was conducted as a result of a Critical Incident System (CIS) intake related to a medication incident.

A Follow Up inspection #2019_615609_0011 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Chief Nursing Officer (CNO), Human Resources Director, Education Lead, Long Term Care (LTC) Coordinator, Registered Dietitian (RD), Activity Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs) and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, the home's internal investigation notes, staff education and training records, employee's files as well as reviewed licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Medication

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

1 WN(s)
1 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 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 residents in accordance with the directions for use specified by the prescriber.

A Critical Incident (CI) report was submitted by the home to the Director which outlined a medication incident. The CI report described how RPN #101 administered a particular medication to resident #001 via a route other than specified in the order.

Inspector #609 reviewed resident #001's health care records and found an order by physician #106 prescribing a particular medication via an identified route.

A further review of resident #001's health care records found a progress note by RPN #101 indicating that they had administered the particular medication to the resident via a different route than prescribed in the order.

A review of the home's policy titled "Medication Program" last reviewed October 2018 required nurses to administer medication to residents safely by verifying the right route.

RPN #101 was unavailable for an interview during the inspection.

A review of RPN #101's Human Resources (HR) file found a letter that disciplined the RPN for creating an "unsafe [resident] condition" and was required to complete medication administration retraining.

A review of the home's internal investigation of the incident found RPN #101 admitted that they administered the particular medication to resident #001 via a route other than what was prescribed in the resident's order.

During an interview with the LTC Coordinator, they verified that RPN #101 did not administer resident #001's particular medication as prescribed.

During an interview with the home's Chief Nursing Officer (CNO), they outlined retraining RPN #101 would have to be complete. [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.

Issued on this 26th day of March, 2019

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

Original report signed by the inspector.