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
Jan 24, 2020	2020_828759_0001	020144-19	Critical Incident System

Licensee/Titulaire de permis

St. Joseph's Health Centre of Sudbury
1140 South Bay Road SUDBURY ON P3E 0B6

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

St. Joseph's Villa, Sudbury
1250 South Bay Road SUDBURY ON P3E 6L9

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

KEARA CRONIN (759)

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): January 9 and 10, 2020

The following intake was completed in this Critical Incident inspection:
- One intake relating to a missing controlled substance

During the course of the inspection, the inspector(s) spoke with the Director of Care, Assistant Director of Care, Registered Nurses, Registered Practical Nurses, Personal Care Attendants, and residents.

The inspector conducted daily observations of the provision of care that was provided to residents, reviewed health care records, polices and procedures, and internal investigation notes.

The following Inspection Protocols were used during this inspection:
Medication

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	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. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area that was secure and locked or in a medication cart.

Two separate times, Inspector #759 observed two medicated creams, on resident #001's bed side table closest to the door in their room.

Inspector #759 reviewed resident #001's electronic records on Point Click Care (PCC) and did not identify a physician's order that permitted resident #001 to store medications in their room.

Inspector #759 interviewed Registered Practical Nurse (RPN) #100 and they confirmed that resident #001 did not have an order for self-administration of medications.

Inspector #759 reviewed the policy titled "The Medication Pass" last revised January 2018, and it stated "do not leave resident's medications at the bedside unless following self-administration policy and procedure". Inspector #759 reviewed the policy titled "Self-Administration of Medications" dated February 2017, it stated "self-administration of medications by a resident is permitted when specifically approved by the prescriber".

During an interview with Inspector #759, Registered Nurse (RN) #104 indicated that "creams are to be kept in [medication] room, not at the bed side". They further indicated that the medicated creams "should be in the [the medication] room".

During an interview with the Director of Care, they also confirmed that the creams should not have been left at the bed side.

The licensee has failed to ensure that two medicated creams were stored in an area that was secured and locked or a medication room. [s. 129. (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 drugs are stored in an area or a medication cart, that is secure and locked, to be implemented voluntarily.

WN #2: 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 #001 in accordance with the directions for use specified by the prescriber.

A Critical Incident (CI) report was submitted to the Director, as a result of a missing controlled substance for resident #001. The CI report indicated that a cup containing medications was found in resident #001's room on the morning of a specified date, from previous a medication pass.

Inspector #759 reviewed resident #001's electronic health care records on PCC and identified that resident #001 was to receive specified medications at a specified time.

Inspector #759 interviewed Personal Care Attendant (PCA) #102 and they indicated that when they checked on resident #001, they noticed a medication cup sitting on the table. They reported this immediately to RPN #109.

A document titled "Medication Incident Form – Original Report" completed by RPN #109, indicated this was a medication incident relating to a "dose omission" and that an "error occurred that reached the patient but did not cause harm". It further indicated that a PCA brought a medication cup with specified medications that was left on the resident's side table and that those medications were to be administered at a specified time.

Inspector #759 identified a written document in the homes investigation notes that was written by RPN #109. It stated that "noted on [electronic medication administration record] that resident is to receive [a controlled substance] at a specified time, however the medication was not present in the [medication] cup".

Inspector #759 interviewed RPN #100 who administered medications to residents in the

home area when the incident occurred. RPN #100 confirmed that they did not watch the resident take their medications. They stated that they gave them their medications and they saw them with the medication cup up to their mouth so they walked out.

The policy titled “The Medication Pass” last revised January 2018, required staff to “administer medications and ensure that they are taken”.

During and interview with Inspector #759 and the Assistant Director of Care (ADOC), the ADOC stated that “the expectation is that the nurse makes sure that the medication is taken physically by the resident before they leave the room”.

The licensee has failed to ensure that resident #001 received their medications on a specified day as prescribed by the physician. [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 28th day of January, 2020

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

Original report signed by the inspector.