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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 17, 2017	2017_607523_0025	023286-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

SUMAC LODGE
1464 BLACKWELL ROAD SARNIA ON N7S 5M4

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

ALI NASSER (523), RHONDA KUKOLY (213)

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): October 10, 11, 12 and 13, 2017

The following inspections were conducted concurrently during this inspection:
Log #016991-16, IL-44844-LO, complaint related to care and services.
Log #009776-17, CIS #2573-000005-17, critical incident related to allegation of staff to resident abuse.
Log #010328-17, CIS #2573-000006-17, critical incident related to allegation of staff to resident abuse.
Log #014089-17, CIS #2573-000009-17, critical incident related to unexpected death of a resident.
Log #021090-17, CIS #2573-000011-17, critical incident related to allegation of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, Nurse Practitioner, Resident Assessment Instrument Coordinator (RAI), pharmacist, Recreation staff member, five registered staff members, three Personal Support Workers (PSW), the Resident Council President, the Family Council President, three family members and 20 residents.

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

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council

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	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. 135. Medication incidents and adverse drug reactions

Findings/Faits saillants :

1. The licensee has failed to ensure that all medication incidents were reviewed and analyzed, and corrective action taken as necessary, and a quarterly review was undertaken of all medication incidents that occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

The medication incidents for a specific period of time were reviewed. There were a total of ten medication incidents documented. Ten out of ten of the incidents involved potential or actual nursing errors and one of the incidents involved a pharmacy error.

A medication incident that was documented as occurring on a certain date involving a specific resident, reported that a specific medication was missing from the strip in the medication cart. The resident was given the dose prescribed from an as needed (PRN) supply. The incident was documented as a pharmacy error and that it did not involve the resident as the resident received the dose as ordered. The pharmacy investigated the error as a pharmacy report and found that there was evidence to prove that the medication was in fact in the strip. This information was not documented by the pharmacy until a later date and the home was not aware of the outcome of the investigation until recently.

In an interview with specific staff member on a certain date they agreed that an analysis of the medication incident was not completed as they were not aware that the pharmacy had found that the medication noted in the incident had not been missing.

A medication incident that was documented as occurring on a certain date involving a specific resident, reported that the resident’s specific medication was ordered on a specific date, and six days later the medication was not available in the home and had not been sent from pharmacy.

In an interview, specific staff members reviewed the electronic Medication Administration Record (eMAR) and found that the medication was documented as administered on the first four days and documented as not available on the last two days. They said that there

had been no follow up with staff related to if the medication was in fact given or not, if the medication was available and if so, where did it come from and why it was documented as given for four days and then not available when the medication incident was completed as not available. They agreed that an analysis of the medication incident was not fully completed related to what had occurred over the seven days from the date of order to the date of the incident report.

A review of the Professional Advisory Committee meeting minutes for a specific date where the quarterly medication incident review was completed. The minutes reported 13 medication incidents were reviewed, several medication errors were pharmacy related and the non-pharmacy related medication incidents resulted in education given to involved individuals. Corporate aware of pharmacy related incidents and working to resolve. In an interview, specific staff members agreed that the quarterly review did not accurately represent the medication incidents for the quarter in that ten medication incidents occurred and ten out of ten involved nursing errors and one involved a pharmacy error.

The licensee failed to ensure that medication incidents involving specific residents were analyzed, and corrective action taken as necessary and that the quarterly review of medication incidents that was completed in certain period of time did not include an accurate representation of the incidents that occurred in the home for a specific period of time.

During the inspection this non-compliance was found to have the severity level of minimal harm/risk or potential for actual harm/risk to residents. The scope of the non-compliance was isolated. This non-compliance was not previously issued. [s. 135.]

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 all medication incidents are reviewed and analyzed, and corrective action taken as necessary, and a quarterly review is undertaken of all medication incidents that occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, to be implemented voluntarily.

Issued on this 17th day of October, 2017

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

Original report signed by the inspector.