Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 6, 7, 11, 2011	2011_035124_0014	Complaint

Licensee/Titulaire de permis

DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC
2121 ARGENTIA ROAD, SUITE 301, MISSISSAUGA, ON, L5N-2X4

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

PERTH COMMUNITY CARE CENTRE
101 CHRISTIE LAKE ROAD, R. R. #4, PERTH, ON, K7H-3C6

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

LYNDA HAMILTON (124)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care, registered nurses, registered practical nurse, RAI Co-ordinator, Activity Co-ordinator, the consulting pharmacist and the resident.

During the course of the inspection, the inspector(s) reviewed the residents' health records, the home's medication policies and procedures and the surplus narcotic medications awaiting destruction.

The following Inspection Protocols were used in part or in whole during this inspection:

Hospitalization and Death

Medication

Recreation and Social Activities

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Definitions	Définitions
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 114. Medication management system

Specifically failed to comply with the following subsections:

s. 114. (2) The licensee shall ensure that written policies 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. O. Reg. 79/10, s. 114 (2).

Findings/Faits sayants :

1. The licensee does not have a written policy and protocol regarding the dispensing of all drugs used in the home, specifically related to the practice of "borrowing".
A resident received medication despite not having a physician's order for the medication.
Two registered nurses and the Director of Resident Care reported to the inspector that registered staff had "borrowed" the medication from other residents' medication supply to use that medication with the resident.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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 subsections:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits sayants :

A resident received a number of doses of medication during a specific time period.
The resident did not have a physician's order in place to prescribe the medication.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits sayants :

1. This non-compliance relates to O.Reg. 79/10, s.114 (2) The licensee shall ensure that written policies 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 findings below demonstrate that these policies and procedures are not complied with, s.8 (1)(b).

The licensee's "Transcribing Physician's Orders to MAR Sheet, Policy 8-3" states that all physician's orders are transcribed accurately and completely to the MAR or TAR sheet."
-A resident's Medication Administration Record (MAR) identified a medication and the resident had no physician's order prescribing that medication.
-The physician's order for the medication was incorrectly transcribed onto the resident's MAR through the incorrect triggering of the multi-fill function on the electronic MAR.

The licensee's "Individual Narcotic Medication Record, Policy 6-6", states "Sign on the 'Individual Narcotic Medication Record' each time a narcotic is administered. Include the date, time, amount given, amount wasted, and the new quantity/balance remaining.
-A resident was prescribed a specific medication.
-The resident's Individual Narcotic Medication Record indicated that there a specific number of tablets remaining at the time the medication was discontinued.
-The number of tablets remaining on the medication card were fewer than the number specified on the resident's Individual Narcotic Medication Record.
-The Director of Resident Care confirmed that one tablet is unaccounted for.

-A resident had a specific medication prescribed.
-The resident's Individual Narcotic Medication Record indicated that there were a specific number of tablets received and that one dose was administered. There was a discrepancy in the number of tablets remaining and the Individual Narcotic Medication Record.
-Review of the resident's Medication Administration Record indicated that the resident had received another dose of the medication that had not been recorded on the Individual Narcotic Medication Record, so the number of tablets remaining was correct.

A resident's Individual Narcotic Medication Record indicated that the resident received a number of doses of medication.
-With the exception of a specific date, the medication that was wasted was not documented.

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 registered nursing staff follow the home's medication policies and procedures related to transcription of physician's orders and recording of narcotics, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

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
(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 sayants :

A resident had a physician's order for an injectable medication.
It is documented that the same vial was used for several doses of the medication given over a period of time.
Product information for the medication states that each vial is intended for single use only and that when the dosing requirement is completed, the unused portion should be discarded in an appropriate manner.
The home did not follow the manufacturer's instructions related to the discarding of the unused portion.
This non-compliance relates to s.129 (1)(a)(iv)

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits sayants :

1. Two registered nurses reported to the inspector that they questioned why this medication was prescribed for this resident.
-The Director of Resident Care reported that it is the expectation that registered staff know why a resident is getting medication, that when the resident is started on new medication it is documented and that the resident is monitored.
-The resident received a number of doses of medication during a specific time period.
-There is no documentation in the resident's health record of monitoring the resident's response to the medication.

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 there is monitoring and documentation of the resident's response to new medications when there is no apparent link to the resident's condition, to be implemented voluntarily.

Issued on this 11th day of July, 2011

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

Lynda Hamilton

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA HAMILTON (124)
Inspection No. / No de l'inspection :	2011_035124_0014
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Jul 6, 7, 11, 2011
Licensee / Titulaire de permis :	DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC 2121 ARGENTIA ROAD, SUITE 301, MISSISSAUGA, ON, L5N-2X4
LTC Home / Foyer de SLD :	PERTH COMMUNITY CARE CENTRE 101 CHRISTIE LAKE ROAD, R. R. #4, PERTH, ON, K7H-3C6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JOYCE FIRLOTTE

To DIVERSICARE CANADA MANAGEMENT SERVICES CO., INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 114. (2) The licensee shall ensure that written policies 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. O. Reg. 79/10, s. 114 (2).

Order / Ordre :

The licensee shall prepare a written plan of correction for achieving compliance by developing written policies and protocols to ensure accurate dispensing of all drugs used in the home, specifically related to the "borrowing" of medication. This plan will include an educational component for registered nursing staff and the monitoring and evaluation activities required to ensure compliance is sustained.

This plan must be submitted to Inspector, Lynda Hamilton at 347 Preston Avenue, 4th Floor, Ottawa, ON K1S 3J4 or by fax at 1-613-569-9670 on or before July 15, 2011.

Grounds / Motifs :

1. The licensee does not have a written policy and protocol regarding the dispensing of all drugs used in the home, specifically related to the practice of "borrowing".
A resident received medication despite not having a physician's order for the medication.
Two registered nurses and the Director of Resident Care reported to the inspector that registered staff had "borrowed" the medication from other residents' medication supply to use that medication with the resident.The licensee does not have a written policy and protocol regarding the dispensing of all drugs used in the home, specifically related to the "borrowing of medication.
(124)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 25, 2011

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Order / Ordre :

The licensee shall ensure that no medications are administered to a resident unless prescribed for the resident.

Grounds / Motifs :

1. A resident received a number of doses of medication during a specific time period.
The resident did not have a physician's order in place to prescribe the medication. (124)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 12, 2011

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION / RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-760

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director

c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Clair Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 11th day of July, 2011

Signature of Inspector / Signature de l'inspecteur : L Hamilton

Name of Inspector / Nom de l'inspecteur : LYNDA HAMILTON

Service Area Office / Bureau régional de services : Ottawa Service Area Office