Ontario

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

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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
Jun 3, 4, 2019	2019_790730_0014	006454-18, 012414-18, 020852-18, 032569-18, 033569-18, 002903-19	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Brierwood Gardens
425 Park Road North BRANTFORD ON N3R 7G5

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

CHRISTINA LEGOUFFE (730), INA REYNOLDS (524)

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): May 27, 28, 29, and 30, 2019.

The following Critical Incident intakes were completed within this inspection:

Critical Incident Log #006454-18/ CI 2678-000012-18
Critical Incident Log #012414-18/ CI 2678-000020-18
Critical Incident Log #020852-18/ CI 2678-000028-18
Critical Incident Log #032569-18/ CI 2678-000040-18
Critical Incident Log #033569-18/ CI 2678-000045-18
Critical Incident Log #002903-19/ CI 2678-000006-19

During the course of the inspection, the inspector(s) spoke with an Executive Director, a Director of Care (DOC), an Associate Director of Care (ADOC), a Social Service Worker (SSW), a Registered Nurse (RN), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

The inspector(s) also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, and reviewed policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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. 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 that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

Ontario Regulation 79/10 s. 114 (2) states, "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."

Specifically, staff did not comply with the home's "LTC-Narcotic and Controlled Drugs Management" policy number CARE13-020.01, effective date August 31, 2016, and "Narcotic and Controlled Substances Administration Record" policy number MEDI-CL-ONT-042, effective date October 1, 2018, which was part of the licensee's medication management program.

The home's policy "LTC-Narcotic and Controlled Drugs Management" policy number CARE13-020.01, effective date August 31, 2016, under procedure stated: "Narcotic and controlled drug discrepancies will be immediately communicated to the DOC/designate, followed by the completion of a Medication Incident Report."

A) The home submitted Critical Incident System (CIS) report #2678-000040-18 to the Ministry of Health and Long-Term Care, related to a controlled substance missing / unaccounted for resident #003.

The CIS report stated that on a specified date, the oncoming day shift Registered Practical Nurse (RPN) #106 had reported to the Director of Care that during the narcotic

shift count with the night shift registered nurse, the blister pack belonging to resident #003 had one tablet of a narcotic missing from pouch number two. The plastic pouch from the front of the blister pack appeared to have been ripped, however the back of the card where staff removed the tablets was still intact. The medication room and cart was searched, but the tablet was not found. This was verified by RPN #106, during an interview.

Physician orders reviewed in Point Click Care (PCC) for resident #003 showed an order for the missing narcotic.

There was no documented evidence to support that a medication incident report had been completed after the narcotic discrepancy was identified.

Record review of the MediSystem Pharmacy "Medication Incident Trends and Action Planning" dated January 2019, showed "No Med incidents logged between Oct-Dec 2018 (inclusive)" and "0 LTC reported medication incidents to pharmacy this quarter (Nursing + Pharmacy)."

B) The home submitted Critical Incident System report (CIS) #2678-000006-19 to the Ministry of Health and Long-Term Care, related to a controlled substance missing / unaccounted for resident #004.

The CIS report stated that on a specified date, the registered staff noticed during their medication administration for resident #004 that the scheduled narcotic blister pack dose for a specified time was missing. The administration record form for the medication had a remaining balance of zero when it should have been 0.5mg left. The Director of Care (DOC) had called the registered practical nurse who had worked the shift of the day prior, and they advised the DOC that they believed they had thrown the blister pack out in the garbage.

Physician orders reviewed in Point Click Care (PCC) for resident #004 showed an order for the missing narcotic.

There was no documented evidence to support that a medication incident report had been completed after the narcotic discrepancy was identified.

In an interview, Associate Director of Care (ADOC) #104 said that they were unable to find a medication incident report for the missing narcotic incidents for resident #003 and

#004. ADOC #104 said staff that discovered the discrepancy should have documented on the Medication Incident Reporting System (MIRS). Director of Care (DOC) #101 acknowledged that a missing/unaccounted controlled substance was considered a medication incident and the home's expectation was that a medication incident report was completed as per policy. DOC #101 also stated that the medication incidents should have been reported to the resident's physician and the pharmacy service provider, as they should have been made aware of the missing narcotics.

The licensee has failed to ensure a medication incident report was completed after staff reported a missing / unaccounted controlled substance for resident #003 and resident #004, as per the home's policy.

C) The home's policy "Narcotic and Controlled Substances Administration Record," policy number MEDI-CL-ONT-042, effective date October 1, 2018, under procedure stated:
"Upon dispensing a narcotic or controlled drug, the pharmacist will prepare a Narcotic and Controlled Substance Administration Record.
The following information must be recorded on the form:
a) Resident name, room number
b) Drug name, strength and dosage form
c) Direction for use
d) Date issued
e) Quantity dispensed
f) Prescription number."
The policy further stated that, "When a page of the narcotic and Controlled Substance Administration Record is completed, the nurse responsible for the last entry on the page must transfer the count to the following page. The nurse must also transfer all the information received from the pharmacy to the subsequent page, including the original quantity of drug dispensed."

Review of resident 003's "Narcotic and Controlled Substance Administration Record" for a specified time period, showed the following:
Room #: BLANK
Medication: [a specified narcotic]
Direction: [specific instructions]
Date Issued: BLANK
Received by: BLANK
Quantity: BLANK
Rx #: BLANK

In an interview, Registered Practical Nurse (RPN) #106 verified the missing documentation on resident #003's narcotic and controlled substance administration record. RPN #106 said that they were told by the previous Director of Care to make sure to transcribe the prescription number on the count sheet. RPN #106 said they would check the prescription number (Rx#) on the administration record against the Rx# on the blister pack, but now they would not be able to do so, as it was missing.

In an interview, Director of Care #101 and Associate Director of Care #104 acknowledged that registered staff should have transferred all the information on the header of the resident's narcotic count sheet when a page of the narcotic and Controlled Substance Administration record was completed, as per policy.

The licensee has failed to ensure that staff transferred all the information received from the pharmacy to the subsequent page of resident #003's narcotic and controlled substance administration record, as per home's policy. [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 adherence to the home's policies relating to the completion of medication incident reports and transfer of information received from the pharmacy to a resident's narcotic and controlled substance administration record, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return of the resident from the hospital.

The home submitted Critical Incident System report (CIS) report #2678-000028-18 to the Ministry of Health and Long Term Care (MOHLTC). The CIS report stated that on a specified date, resident #005 was found sitting on their toilet with their bandage saturated. The resident was transferred to hospital and required a medical intervention.

A review of resident #005's progress notes in Point Click Care (PCC) stated that on an earlier date the resident was transferred to hospital and had a medical intervention. The resident returned to the home a few days later.

A review of the electronic Treatment Administration Record (eTAR) for resident#005, indicated that during this time period resident #005 had another area of altered skin integrity, which was being monitored.

A review of the assessment section in PCC did not show a Head to Toe Skin Assessment completed for resident #005, in the assessments section of PCC, after their return from hospital.

A review of the home's procedure titled "LTC- Procedure Steps: Prevention of Skin Breakdown" Index: Care12-O10.01, with a reviewed date of March 31, 2019 stated in part "All Residents will have a Head to Toe Assessment: Upon return from the hospital."

During interviews with Registered Practical Nurses (RPNs) #106 and #108 and Associate

Director of Care (ADOC) #104, they stated that Head to Toe Skin Assessments should be completed when a resident returns to the home from hospital. They stated that these assessments were completed in the assessment section of PCC.

ADOC #104 stated that resident #005 was at risk of altered skin integrity. The ADOC stated that it was their expectation that a Head to Toe Skin Assessment would have been completed for resident #005 after their return from hospital. They also stated that a Head to Toe skin assessment was not completed.

The licensee has failed to ensure that when resident #005 returned from hospital that they received a skin assessment by a member of the registered nursing staff. [s. 50. (2) (a) (ii)]

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 residents at risk for altered skin integrity receive a skin assessment after any return of the resident from the hospital, to be implemented voluntarily.

Issued on this 4th day of June, 2019

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

Original report signed by the inspector.