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
Jul 17, 2020	2020_730593_0008	011462-20	Complaint

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

Heartwood
201 - 11th Street East CORNWALL ON K6H 2Y6

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

GILLIAN CHAMBERLIN (593)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): Offsite inspection dates June 10 - 12, June 23 - 24, 2020.

Complaint log #011462-20 was inspected related to a medication error where a resident was administered medications for which they were not prescribed.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nursing staff and family members.

The Inspector also reviewed resident health care records, investigation records and Licensee policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **2 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. 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 system, the system was complied with.

In accordance with r. 114. (1), Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. (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.

Specifically, staff did not comply with the licensee's "Medication Administration", procedure CARE13-O50.01, revision date March 31, 2019 and the licensee's "Resident Identification Process", procedure CARE10-O10.10, revision date March 31, 2019, both of which are part of the home's medication management system.

A complaint was submitted to the Director, related to an incident where resident #001 was administered multiple medications not prescribed, in error.

A review of the licensee's "Medication Administration", procedure CARE13-O50.01, revision date March 31, 2019, found the following:

Procedure
• Two resident identifiers are required before administering medications.

A review of the licensee's "Resident Identification Process", procedure CARE10-O10.10,

revision date March 31, 2019, found the following:

Procedure
• All Health Care Providers, including external health providers will verify the Resident's identity before providing any service, procedure, treatment and/or medication administration.

A review of the home's investigation records, found the following:

There were nine medications administered to resident #001 in error.

During an interview with Inspector #593, June 23, 2020, Registered Practical Nurse (RPN) #100 indicated that they were new to the first-floor home area and unfamiliar with the residents. They added that it was dark in the hallway and they had difficulty finding the resident to administer medications. After the medications were administered to resident #001, the RPN realized they had administered the medications to the wrong resident and they immediately reported the error to the charge RN.

During an interview with inspector #593, June 24, 2020, DOC #101 indicated that the medication error made by RPN #100 was a combination of factors including, the RPN being unfamiliar with residents on the first floor, the layout of the room numbers on the first floor and the RPN failing to sufficiently check the residents name prior to administration of the medications.

Resident #001 was administered medications that were not prescribed for them after RPN did not adequately identify the resident prior to administration. As such, the licensee has failed to ensure that the required procedures "Medication Administration" and "Resident Identification Process", were complied with. [s. 8. (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 ensuring that 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 is complied with, 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. (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 saillants :

1. The licensee has failed to ensure that no drug is used by or administered to resident #001 unless the drug has been prescribed for the resident.

A complaint was submitted to the Director, related to an incident where resident #001 was administered multiple medications not prescribed, in error.

A review of the home’s investigation records, found the following:

There were nine medications administered to resident #001 in error.

During an interview with Inspector #593, June 23, 2020, RPN #100 indicated that they were new to the first-floor home area and unfamiliar with the residents. They added that it was dark in the hallway and they had difficulty finding the resident to administer medications. After the medications were administered to resident #001, the RPN realized they had administered the medications to the wrong resident and they immediately reported the error to the charge RN.

During an interview with inspector #593, June 24, 2020, DOC #101 indicated that the medication error made by RPN #100 was a combination of factors including, the RPN being unfamiliar with residents on the first floor, the layout of the room numbers on the first floor and the RPN failing to sufficiently check the residents name prior to administration of the medications.

Resident #001 was administered medications that were not prescribed for them after RPN did not adequately identify the resident prior to administration. As such, the licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. [s. 131. (1)]

Issued on this 17th day of July, 2020

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

Original report signed by the inspector.