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 8, 2020	2019_781729_0027	022419-19, 023110-19	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

The Village Seniors Community
101-10th Street HANOVER ON N4N 1M9

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

KIM BYBERG (729)

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): December 16, 17, 18, 19, 23, 31, 2019, and January 2, 3, 6, 7, 2020.

The following intakes were completed during this critical incident inspection:
Log #022419-19, related to resident to resident responsive behaviours;
Log #023110-19, related to medication incidents.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Activation Manager, Registered Nurse (RN), Registered Practical Nurse (RPN), Security Guard, Personal Support Workers (PSW), and Residents.

Complaint inspection #2019_781729_0028 was completed concurrently with this critical incident system inspection.

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

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

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	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. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident was reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

A critical incident (CI) report was submitted to the Ministry of Long-Term Care (MLTC) on a specified date, with details related to a medication incident for resident #001.

On a specified date, RPN #106 administered a narcotic analgesic to resident #001. Resident #001's electronic medication administration record (eMAR) stated that the medication was to be administered orally every morning.

A review of the home's narcotic and controlled drug administration record (NCDA) stated that on a specified date, the count of the narcotic analgesic showed four capsules remaining. When RPN #106 documented the administration of the narcotic analgesic, they documented the count as three capsules remaining. The documentation of three capsules remaining was written over, and the number two remained.

Two days later on a specified date, an RPN administered the last capsule of the narcotic analgesic in the card, and noted that there should have been one capsule remaining. The RPN reported the incident to the DOC.

The home's investigation notes stated that RPN #106 initially signed the NCDA form as having three capsules remaining, they went back to check the card and noted only two capsules remained and changed the count. They did not notify the charge nurse, DOC or any other person about the missing dose of the narcotic analgesic.

DOC #100 stated that RPN #106 should have notified the charge nurse, the Physician, resident and or substitute decision maker (SDM), and pharmacy immediately. As a result, the home could not follow up immediately and investigate the incident.

The licensee failed to ensure that the medication incident involving resident #106 was reported. [s. 135. (1)]

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 every medication incident involving a resident and every adverse drug reaction is, reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

Issued on this 15th day of January, 2020

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

Original report signed by the inspector.