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
Aug 28, 2018	2018_751649_0013	003835-18	Complaint

Licensee/Titulaire de permis

Villa Colombo Seniors Centre (Vaughan) Inc.
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

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

Villa Colombo Seniors Centre (Vaughan)
10443 Highway 27, Kleinburg VAUGHAN ON L0J 1C0

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

JULIEANN HING (649)

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): Jun 26, 27, 28, July 3, 4, 5, 6, 9, and 18, 2018.

The following intake was inspected:
Complaint log #003835-18 related to a medication allegation

This inspection was also conducted concurrently with complaint logs #010460 and #012516-18 (related to transferring, continence care, abuse and plan of care) completed under Inspection Report #2018_524500_0009 dated August 27, 2018. A written notification (WN) and voluntary plan of correction (VPC) related to LTCHA S.O 2007, c.8, s. 3. (1) 11. iv. was identified in that inspection and has been issued in this report(#2018_751649_0013) dated August 28, 2018.

During the course of the inspection, the inspector(s) spoke with the Administrator, Clinical Manager, Registered Nurses (RNs), Nurse Designate, Registered Practical Nurses (RPNs), RAI-MDS Coordinator, Pay Roll Clerk, Residents and Family members.

During the course of the inspection the Inspector observed medication administration, reviewed relevant policies and procedures, observed staff to resident interactions, reviewed relevant policies and procedures, conducted interviews and reviewed residents' health records.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.

6 WN(s)
4 VPC(s)
1 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) alleging that resident #010 had received double the prescribed dose of an identified medication.

A review of the home's medication incident report indicated resident #010's received a double dose of an identified medication by the registered staff. Follow up corrective action identified on the medication incident report was to have two nurses check and co-sign for the administration of the medication daily.

A review of the progress notes indicated documentation by the Administrator confirming that there was a medication error on an identified date and the Administrator confirmed same in an interview.

In interviews the Clinical Manager and Registered Nurse (RN) #113 confirmed that the medication was not administered to resident #010 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted. Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

On June 20, 2018, at approximately 1600 hours the Inspector observed the electronic medication administration record (e-MAR) screen on the medication cart outside the nursing station on an identified home unit open with a resident's personal health information (PHI) being displayed. Approximately five residents and a visitor were observed sitting a few feet from the medication cart and one resident sitting close to the medication cart in their wheelchair. The Inspector observed when the nurse was made aware of the situation by the RAI-MDS Coordinator they came over to the medication cart and locked the e-MAR screen and the medication cart.

In an interview, Registered Practical Nurse (RPN) #117 could not recall if they had left the e-MAR screen unlocked.

In an interview the RAI-MDS Coordinator confirmed the e-MAR screen had been left unlocked when it was not in use.

In an interview the Clinical Manager confirmed that the e-MAR screen should have been locked when the nurse stepped away from the medication cart to ensure confidentiality of residents' personal health information. [s. 3. (1) 11. iv.]

2. The inspector observed the point of care (POC) computer screen opened at the nursing station on July 18, 2018, at 1225 hours, on an identified home unit. There was a housekeeping staff working around the nursing station. The registered staff and all Personal Support Workers (PSWs) were assisting residents in the dining room at the same time.

Interviews with RPN #115 and the Administrator confirmed that the screen should not be open and visible to anyone, and staff should have logged out after completing the documentation. (500) [s. 3. (1) 11. iv.]

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 the following rights of residents are fully respected and promoted. Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) alleging that resident #010 had received double the prescribed dose of an identified medication.

A review of resident #010's e-MAR which was part of the resident's plan of care directed the nurse to sign for the medication alternating on the resident's identified body areas. According to the e-MAR an order was initiated for a second nurse to check and confirm the correct administration of the medication.

A review of resident #010’s progress notes indicated on an identified date a family member brought to the attention of the nurse that the resident's medication was not administered to an identified body area as was directed in the resident's the plan of care.

In interviews the Clinical Manager and RN #113 confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan as the medication was not administered on the resident’s identified body area as was directed in the e-MAR. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) alleging that resident #010 had received double the dose of an identified medication.

A review of resident #010’s e-MAR which was part of the resident's plan of care directed the nurse to sign for the medication alternating on the resident's identified body areas. According to the e-MAR an order was initiated for a second nurse to check and confirm the correct administration of the medication.

A review of the resident’s e-MAR indicated the second check by the nurses confirming the correct administration of the medication was not documented on two identified dates.

In interviews with RN #118 and #113 who had worked on those dates and were the second nurses assigned to check that resident #010's medication was correctly administered confirmed they had not documented on the resident's e-MAR.

In an interview the Clinical Manager confirmed those dates the second nurses assigned to check and confirm that the resident's medication was correctly administered had not documented on the resident's e-MAR. [s. 6. (9) 1.]

3. Resident #015 was randomly selected as a result of non-compliance identified with resident #010.

A review of resident #015’s e-MAR indicated several medications were not signed on an identified date.

In an interview with RN #114 who worked on an identified date told the Inspector that the resident had refused their medications and they had not completed the documentation on the e-MAR to indicate the resident’s refusal.

In an interview the Clinical Manager acknowledged if resident #015 refused or declined their medications it should have been documented. [s. 6. (9) 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 the care set out in the plan of care is provided to the resident as specified in the plan and that the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #4: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with O. Reg. 79/10, s. 114, the licensee was required to ensure that the medication management system included written policies and protocols were 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 policy regarding physician orders - policy #RC 04-04-03 dated July 1, 2010, which is part of the licensee's medication management system.

A review of the home's policy titled Narcotics and Controlled Medication, policy #RC 04-04-03 dated July 1, 2010, indicated following the administration of the narcotic, the Registered Nursing Staff will record the administration of the medication on the MAR record and also on the narcotic counting form as per the pharmacy policy and procedure:
-include the date, time,
-amount given,
-amount wasted,
-and new quantity/balance remaining.

1. During the Resident Quality Inspection (RQI) while conducting a narcotic count with RPN #110 on an identified home unit it was identified that the narcotic count did not match the narcotic and controlled substance administration record for residents #014, #015, #013, and #016.

In an interview, RPN #110 acknowledged that the residents' narcotic and controlled substance administration records had not been completed and signed at the time of administration.

2. During the RQI as part of the sample expansion while conducting a narcotic count with RN #113 on an identified home unit it was identified that the count on resident #018's narcotic card did not match the narcotic and controlled substance administration record.

In an interview RN #113 told the Inspector they had administered resident #018's medications before lunch. As of time of interview with RN #113 the narcotic and controlled substance administration record for resident #018 was not completed.

In an interview the Clinical Manager confirmed that the home's policy had not been followed by RPN #110 and RN #113 and stated at the time of administration, the date, time and number of tablets given should have been documented on the residents' mentioned above narcotic and controlled substance administration record at the time of administration. [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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply including all areas where drugs were stored shall be kept locked at all times, when not in use.

A review of the home's policy titled Medication Cart, policy #RC 04-01-04, dated August 1, 2010, indicated medication carts must be locked when regulated staff is not immediately attending the cart.

On June 20, 2018, at approximately 1600 hours the Inspector observed the medication cart outside the nursing station on an identified home unit unlocked. In the drawers the Inspector observed residents' medication pouches and other medical supplies. Approximately five residents and a visitor were observed sitting a few feet from the medication cart and one resident sitting close to the medication cart in their wheelchair. The Inspector observed when RPN #117 was made aware of the situation by the RAI-MDS Coordinator they came over to the medication cart and locked the e-MAR screen and the medication cart.

In interviews RPN #117 and the RAI-MDS Coordinator confirmed that the medication cart on an identified home unit should not have been left unlocked when unattended. According to the RAI-MDS Coordinator they had observed the Inspector opening the medication drawers and located the nurse who was in the medication room at the time and alerted them to the situation.

In an interview the Clinical Manager confirmed that the medication cart should be kept locked at all times when the nurse steps away from the cart and should not be accessible to visitors or residents. [s. 130. 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 steps are taken to ensure the security of the drug supply including all areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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 O. Reg. 79/10, s. 129 (1).
(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 saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart, that was used exclusively for drugs and drug-related supplies.

A review of the home's policy titled Medication Cart, policy #RC 04-01-04, dated August 1, 2010, indicated no other items are to be stored in the medication cart, including residents' valuables such as jewelry.

During the RQI while conducting a narcotic count on an identified home unit the Inspector observed in the narcotic drawer the following none drug-related supplies:
-Two digi-pen refills
-One earring belonging to resident #013

In interviews the Clinical Manager and the RPN #110 confirmed that the above mentioned items should not have been stored in the narcotic drawer. [s. 129. (1) (a)]

Issued on this 28th day of August, 2018

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

Original report signed by the inspector.