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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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 17, 2020	2020_768693_0009	001774-20, 010076-20	Critical Incident System

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street THUNDER BAY ON P7B 5G7

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

Bethammi Nursing Home
63 Carrie Street THUNDER BAY ON P7A 4J2

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

MELISSA HAMILTON (693), LAUREN TENHUNEN (196)

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): June 1 to 4, and 8 to 11, 2020.

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:
-one intake, regarding alleged improper care of a resident; and
-one intake, regarding missing controlled substances for multiple residents.

Complaint inspection #2020_768693_0008 and Follow Up inspection #2020_768693_0010 were conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Clinical Manager (ACM), Best Practice Registered Nurse, Pharmacist/ Pharmacy Owner, Consultant Pharmacist, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services

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. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written medication management policies and protocols were developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A CIS report was submitted to the Director, for an incident regarding missing and unaccounted specific medications, for an identified number of residents. The CIS report indicated that a discrepancy was noted in the home's specified medication count on an identified date, and the home's investigation identified that RPN #100 had admitted to a particular activity related to medications, over an unspecified, extended period, for their own personal use.

The College of Nurses of Ontario Practice Standard, titled, "Medication", 2019, indicated that nurses promoted safe care, and contributed to a culture of safety within their practice environments, when involved in medication practices. In addition, nurses were to promote and implement strategies to minimize the risk of misuse and drug diversion.

Inspector #693 reviewed the home's investigation file. The home's investigation identified that RPN #100 had been participating in identified activities by means of a specified number of different ways, and that in a meeting with this RPN, they admitted to the identified activities, as well as the ways in which they were completed. RPN #100 informed the home that they would complete an identified task, that was not part of their normal job routine, to prevent other nurses or management from discovering the identified activities that they had partaken in. The home's investigation identified that an identified number of specific medications, were missing over the investigation period.

During separate interviews with the Administrator, DOC, ACM, Consultant Pharmacist, and the Pharmacist/ Pharmacy owner, they indicated that the ways in which RPN #100, was participating in a specific activity, were never noticed by staff or management of the home, or by the Pharmacy. They indicated that there were multiple portions of the medication management polices that RPN #100 had found a way around, in order to have participates in the identified activities.

During separate interviews with RPNs #101, #105, and #110, they indicated that they followed the “Eight Rights of Medication Administration”, when administering medications, including specific medications. The RPNs stated that when they administered a specific medication to a resident, they documented the medication on the specified medication count sheet, to ensure the medication was properly accounted for as well as on the resident’s eMAR. They indicated that they would borrow a specific medication from another resident, if a resident was out of the specific medication and waiting on refills from pharmacy and in this case, the documentation would require two nurse’s signatures on the two specific medication count records as well as on a specific borrowing record. The RPN’s showed Inspector #693 the specified medication count sheet, and stated that once this record was completely filled in, it was to be given to the DOC or ACM.

Inspector #693 reviewed the home’s medication management policies:

The home's policy from Janzen's pharmacy, titled, "5.5 Administration of Medications-General Guidelines", last revised March 2020, indicated that medications were to be administered in accordance with written orders of the Physician or other authorized prescriber. The "Steps in Medication Administration" portion of the policy outlined that the nurse was to administer medications following the eight rights of medication administration: 1. Right resident; 2. Right Medication; 3. Right Dose; 4. Right Time; 5. Right Route; 6. Right Reason; 7. Right Response; and, 8. Right Documentation. In addition, that medication administration was documented in the resident's Medication Administration Record at the time the medication was administered.

The home's policy from Janzen's pharmacy, titled, "1.6 Borrowing of Medications", last revised March 2020, indicated that when a medication was borrowed from one resident for another resident, the nurse was to document on the” Borrowing of Medication Control Sheet”, and have a second nurse verify that the correct medication was borrowed. If the borrowed medication was a controlled or narcotic medication, the removal of inventory from one unit or resident’s narcotic record was required to be documented. The borrowed

medication was then added to the receiving unit or resident's narcotic record according to the facility's narcotic and controlled drug policy. Double signatures were required at each point of pickup and removal between nursing units. As well, that when the control sheet was full, the original copy was to be submitted to Nursing Administration. Nursing was responsible for entering this order into the eMAR and documenting administration.

The home's policy, titled, "Narcotic and Controlled Substances- Bethammi, LTC 11-11", last updated April 17, 2019, indicated that the narcotic and controlled substance count would be completed by two nurses, and that the record would be thoroughly inspected by the nurses counting. In addition, that when the narcotic and controlled drug records were completed, they were to be placed in the manager’s mailbox.

During separate interviews with the DOC, and the ACM, they indicated that specific medication audits were being completed weekly in the home, but the discrepancies were never identified. The DOC and ACM, indicated that several medication management polices in the home were not implemented through RPN #100’s practice, in accordance with evidence-based, and prevailing practices and this allowed for the narcotics to be misappropriated by the staff member. [s. 114. (3) (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 to ensure that the written policies and protocols are developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A CIS report was submitted to the Director, for an incident of improper/incompetent treatment of a resident. The report indicated that resident #026 was aided with a specified Activity of Daily Living (ADL) in an identified way by PSW #108 without the assistance of a second person.

A review of the home's policy, titled, "Minimal Lift - HR 7-221", revised September 17, 2019, indicated that two trained staff were required at all times when performing a mechanical lift.

During an interview, PSW #103, reported to the Inspector that they had become aware that PSW #108 had aided resident #026 with a specified ADL on their own. They further reported that they then assisted with another identified ADL of this same resident shortly afterward as they were positioned improperly in their ambulation device. They added that they then reported the incident to the registered staff.

During interviews, PSW #106, and PSW #111 both reported to the Inspector that a specified number of staff must be present at all times, during assisting a resident with an identified ADL.

In an interview with the DOC, they reported to the Inspector that PSW #108 had completed training on policies related to the identified on January 21, 2020, and they were aware of the need for a specified number of staff, for this ADL.

CO #003 was issued during inspection #2020_633577_0003 pursuant to Ontario Regulation 79/10, s. 36, with a compliance due date of March 13, 2020. As the compliance date was not yet due at the time of this incident, this finding will be issued as a WN to further support the order. [s. 36.]

Issued on this 18th day of June, 2020

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

Original report signed by the inspector.