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
Mar 1, 2019	2019_785732_0005	025686-18, 025934-18, 029043-18, 032570-18, 003869-19	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care Cobden
12 Wren Drive P.O. Box 430 COBDEN ON K0J 1K0

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

EMILY BROOKS (732), AMANDA NIXON (148)

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): February 25, 26, 27, and 28, 2019.

The following intakes were completed in this Critical Incident System Inspection:.

Log #029043-18 (CIS #2827-000032-18) related to resident to resident physical abuse.
Log #003869-19 (CIS #2827-000004-19), Log #025934-18 (CIS #2827-000027-18), and Log #025686-18 (CIS #2827-000026-18) related to falls.
Log #032570-18 (CIS #2827-000035-18) related to controlled substance missing/unaccounted for.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN's), a Registered Practical Nurse (RPN), Personal Support Workers (PSW's), and residents.

The inspector(s) also reviewed residents health care records, observed the medication cart, observed resident rooms and common areas, and observed the delivery of resident care and services.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate actions were taken in response to any medication incident involving a resident.

A critical incident report (CIR) was submitted to the Director describing that the day shift nurse approached resident #002 to apply a new medication patch and discovered that the resident's previous patch was missing. The CIR indicates that the patch had been in place the previous two days and was checked every shift.

The health care record and CIR described resident #002, as having pain. Interventions for pain management included a physician order for a medication patch; one patch to be applied every third day. In review of the electronic Medication Administration Record for a specified month, the resident had a medication patch applied on a specified date.

The Inspector reviewed the electronic Treatment Administration Records for two specified months, whereby the home documents patch placement checks each shift, there were no such checks in place for resident #002.

In an interview with the home's Administrator, Inspector #148 reviewed the actions taken by the licensee in response to the identified medication incident. With the exception of the submitted CIR to the Director, the Administrator was unable to provide any

documents supporting actions taken in response to the medication incident. In discussion of the actions taken, the Administrator indicated that staff were interviewed and the home was searched for the missing patch. When asked by the Inspector, the Administrator could not confirm the staff that had been interviewed. The Administrator suspected day shift registered staff were interviewed; noting that it was possible that other staff had been interviewed. The Inspector asked if the investigation made an attempt to determine the length of time the resident was potentially without the medication patch. The Administrator indicated that it was only yesterday, after the Inspector had inquired about resident #002, that it came to the Administrator's attention that resident #002 did not have shift checks in place to ensure that the medication patch was applied. The Inspector asked if the site of application on a specified date was known, and if direct care staff had been interviewed related to their knowledge of when the patch was last seen. The Administrator could not confirm that such actions were taken at the time of the incident. The Inspector noted the use of an as needed medication that was administered to the resident on a specified date; the Administrator could not confirm if this administration was considered when responding to the medication incident.

The licensee failed to take appropriate actions, specifically in determining the length of time the resident was without the physician ordered medication or ensuring that placement checks each shift were in place.

(Log #032570-18) [s. 134. (b)]

Issued on this 1st day of March, 2019

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

Original report signed by the inspector.