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 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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 19, 2017	2017_589641_0027	019253-17	Resident Quality Inspection

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 MARMORA
58 BURSTHALL STREET P.O. BOX 429 MARMORA ON K0K 2M0

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

CATHI KERR (641), SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 21, 22, 23, 24 and 25, 2017

The following critical incident logs were inspected: Log #012914-17 related to a resident falling resulting in an injury and Log #015460-17 related to a medication incident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the RAI Coordinator, the Nutrition Care Manager, the Maintenance Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Activation staff, Housekeeping staff, the Resident Council President, the Family Council President, residents and residents' family members. During the course of the inspection, the Inspectors conducted a full tour of the home; observed resident care including observing medication administration and written processes for handling of medication incidents and adverse drug reactions; observed and reviewed infection control practices; reviewed resident heath care records, staffing schedules for the nursing department, cleaning schedules, the minutes of the resident council and family council, and policies and procedures related to the skin and wound program, falls prevention program, the restraint monitoring and evaluation documents; and medication management.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Admission and Discharge
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Quality Improvement
Residents' Council
Skin and Wound Care

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

2 WN(s)
2 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	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. 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 the licensee's medication policy for ordering medications from the emergency pharmacy was complied with.

O. Reg 79/10, s. 114 .(2) states 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.

The Pharmacy Policy and Procedure Section 4 " Ordering and Receiving Medication" Policy 4-8 Titled "Ordering Medication from Emergency Pharmacy"

Policy: Medications needed on an emergency basis to ensure the comfort and safety of the resident are supplied in a timely manner according to prior arrangement between the home's pharmacy provider and a designated emergency pharmacy.

Procedure:
1. If medication is not available in the emergency starter box telephone the designated emergency pharmacy and ensure you are speaking to the pharmacist.
2. Inform the pharmacist of the urgency of the order (stat,needed by what time)
4. fax the completed emergency pharmacy order sheet form along with prescriber's order and a copy of the current MAR to the emergency pharmacy.

In reference to Log # 015460-17

On a specified date, a critical incident report was submitted to the Ministry of Health and Long Term Care that indicated that resident #004 was prescribed a medication that the resident did not receive for 6 days, and subsequently experienced a complication.

During an interview with RN #101, she indicated that on a specified date at the noon dose, she noted on the electronic medication administration record (EMar) that the medication was not available. RN #101 indicated that she reordered the medication from pharmacy at that time, however due to back order status and a weekend, the medication was unavailable to send. The pharmacy provider notified the home that the medication would be sent as soon as possible. RN #101 indicated that the order delivery status should have been clarified with the pharmacy, and ordered from emergency pharmacy as per policy, to ensure the medication was administered to resident #004 as prescribed.

During separate interviews with RPN #106, #107 and RN # 101 they indicated it was noted on the EMar that the medication was not available and that pharmacy would dispense it as soon as possible. RN#101 and RPN #106 and #107 indicated that they did not order the medication from the back up pharmacy as per policy.

The Director of Care was interviewed and indicated that due to the weekend and back order status, the pharmacy had sent a message advising the staff that the medication could be delayed as much as 5-6 days. She indicated that the staff member that received the notice did not share the communication or contact the emergency pharmacy. [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 to ensure that the pharmacy policy for ordering medications from the emergency pharmacy are complied with, to be implemented voluntarily.

WN #2: 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 has failed to ensure that the medication incident involving resident #004 was reported to the resident's SDM, the physician, the pharmacy and the DOC.

On a specified date,a critical incident report was submitted to the Ministry of Health and Long Term Care that indicated that resident #004 was prescribed a medication. The resident was not administered the medication for six days and subsequently experienced a complication.

During separate interviews with RPN #106 #107 and RN # 101 and review of resident #004's progress notes they indicated that they had not notified the physician or the SDM of the medication incident.

The Director of Care indicated that 11 days after the incident occurred, she discovered the incident, immediately began an investigation and notified the physician and the SDM of the medication incident at that time. [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 medication incidents are reported to the resident's SDM , the prescriber, the pharmacy and the DOC, to be implemented voluntarily.

Issued on this 20th day of September, 2017

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

Original report signed by the inspector.