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
Oct 1, 2020	2020_505103_0014	013280-20, 018270-20	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 Marmora
58 Bursthall Street P.O. Box 429 MARMORA ON K0K 2M0

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

DARLENE MURPHY (103)

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): September 18, 21, off-site September 22, 23, 2020.

The following intakes were inspected:
Log #013280-20 (CIS #2718-000010-20)-resident fall that resulted in an injury,
Log #018270-20 (CIS #2718-000013-20)-controlled substance missing/unaccounted.

During the course of the inspection, the inspector(s) spoke with a resident, Personal Support Workers (PSW), Registered Practical Nurses (RPN), the Pharmacist associated with this home, the Director of Care (DOC) and the Executive Director (ED).

During the course of the inspection, this inspector made resident observations related to fall prevention, reviewed resident health care records, the licensee's medication policies: "Handling of Medications-Crushing Medications", #5-3 revised February 2017, "Handling of Medications-Drug Destruction and Disposal", #5-4 revised February 2020, "Handling of Medications-High Alert Medications", #5-7 revised June 2018, "Monitored Medications-Storage of Monitored Medications", #6-4 revised February 2017, "Monitored Medications-Shift Change Monitored Drug Count", #6-6 revised November 2018, "Documentation and Record Keeping-Medication Administration Record (MAR/TAR)", #8-1 revised February 2017, "Documentation and Record Keeping-PRN Administration and Documentation", #8-4 revised February 2017 and reviewed the home's investigation into the missing controlled substances.

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

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

5 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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The Executive Director and the Director of Care had reasonable grounds to suspect there was unlawful conduct that resulted in harm or risk of harm to a resident and failed to immediately report the information upon which it was based to the Director.

The home submitted a critical incident report to inform the Director of missing/unaccounted controlled substances. The home's investigation notes indicated alleged, unlawful conduct related to medication practices were identified and investigated one month prior to the submission of the report to the Director.

Sources: CIS (critical incident system), interviews with the Executive Director and DOC and review of the home's investigation notes related to the alleged incidents. [s. 24. (1)]

WN #2: 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. (2) 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. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. The licensee failed to ensure written policies and procedures were developed for the medication management system to ensure accurate destruction and disposal of controlled substances.

Staff reported the wasting of unused portions of controlled substances required a second staff member as a witness prior to the disposal of the medication. On the night shift, only one registered staff member works and unused portions of controlled substances were to be saved within the medication cart and verified by the oncoming registered staff in the morning prior to disposal.

An RPN stated on two consecutive mornings, the RPN from the previous shift reported they had dropped an ampoule that contained a controlled substance on the floor and the vial had shattered leading to the wasting of the entire ampoule. The vial was not saved on either occasion for verification of the wastage. The licensee did not have a policy or procedure developed to ensure the accurate destruction and disposal of the unsued portions of controlled substances.

Sources: Interviews with staff and the DOC, a review of the home’s investigation notes related to the alleged incidents and the licensee's medication policy. [s. 114. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee failed to ensure drugs remained in the original labelled packaging provided by the pharmacy until administered to the residents.

Staff members stated during shift change count, they witnessed an RPN removing medications from their packaging and placing them in as many as ten separate medication cups for their upcoming shift. When the RPN was questioned about this practice, they indicated they knew which residents would require the medications during the shift. All drugs must remain in the original labelled package until administered to the residents.

Sources: Interviews with staff members and a review of the licensee's medication policy. [s. 126.]

WN #4: 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 failed to ensure drugs were stored in a medication cart that was used exclusively for drugs and drug-related supplies.

Staff members observed a bottle of pills stored in the medication cart that was not from the home's pharmacy. The pill bottle was identified by an RPN as containing their personal medications. Only resident drugs and drug-related supplies are permitted to be stored in the medication cart.

Sources: Interview with the Executive Director and a staff member and review of the home's investigation into the alleged incidents. [s. 129. (1) (a)]

WN #5: 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 failed to ensure drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

During change of shift, staff discovered an empty capsule in the medication cart. An RPN stated they had forgotten to discard the outer capsule but the contents had been removed. The RPN stated they routinely opened the capsule and mixed the contents in applesauce prior to administering the medication to one of the residents.

The resident was prescribed the medication twice a day for pain control. The medication record indicated “do not crush” for this medication. Opening the capsule and mixing the contents with applesauce was not in accordance with the directions for use specified by the prescriber as the resident could have crushed the medication while attempting to swallow.

Sources: Interview with a staff member, the Pharmacist and the DOC, a review of the resident's medication record and the licensee's medication policy. [s. 131. (2)]

Issued on this 5th day of October, 2020

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

Original report signed by the inspector.