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 28, 2018	2018_664602_0019	008572-18	Complaint

Licensee/Titulaire de permis

Carveth Nursing Home Limited
375 James Street GANANOQUE ON K7G 2Z1

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

Carveth Care Centre
375 James Street GANANOQUE ON K7G 2Z1

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

WENDY BROWN (602)

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): Sept 13, 14, and 17 - 19, 2018.

The following intake was completed:
Log# 008572-18 regarding multiple care related concerns.

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Food Services Supervisor (FSS), the Activities Director, Activities staff, the Assistant Director of Care (ADOC) the Director of Care (DOC), the physiotherapy assistant, the Administrator and family members.
In addition, observations of resident care, resident-staff, and staff -visitor interactions, snack delivery and provision of physiotherapy services were completed. A review of relevant Long-Term Care home policies including medication administration, the prevention of abuse and neglect and falls prevention was conducted.

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

During the course of this inspection, Non-Compliances were issued.
- **2 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	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 that any procedure instituted or otherwise put in place is complied with.

Resident #001 was admitted to Carveth Care Centre on a specified date with multiple needs. A review of the care plan indicated resident #001 required specific care.

In an effort to address concerns expressed by resident #001's family, the Administrator and the Director of Care (DOC) met with resident #001's Power of Attorney (POA) on a specified date to discuss care issues. At this meeting a specified care procedure was agreed to:

> A tracking form would be posted for staff to sign after performing specified care. This form will be monitored on a daily basis for staff compliance, by the Assistant Director of Care (ADOC), or the DOC.

The care tracking procedure was communicated to staff in the shift change reporting book.

The completion rate on the care tracking sheets was reviewed as follows: Month one – 90 percent (%), Month two - 77%, Month three – 86 % and Month four – 78 %, average completion rate -83%.

In an interview the complainant indicated that care completion had improved significantly since the tracking sheet was put in place, however, any blank spaces were still of concern.

During the course of the inspection, interviews were conducted with several PSW staff, #114, #117, #118 and #119; all of whom indicated the care sheet is to be initialed after providing care and that if the resident refused care, an "R" should be noted. The licensee failed to ensure that the care tracking procedure has been complied with. [s. 8. (1) (a)]

2. On a specified date at a specified time RPN # 106 mixed resident #001's medications with a drink and left them with a family member to administer during the meal. Resident #001 refused to drink most of the liquid requiring the family member alert RN #120 that resident #001 had not received the correct dose of medication. RN #120 contacted the

on call physician and obtained an order for a one time dose of the missed medication.

The Gibson Group Policy and Procedures Manual Medication Policy indicates:
Page B-15
4. Oral medications are managed by registered nursing staff
5. Medications are administered only upon a physicians order by an RN or RPN,

Page B-16
18. Nurse pouring medication is responsible for administering the medication to the resident
19. Nurse is to remain with the resident until all medication is taken.

Page B-29 outlined:
The medication incident report is to be completed in its entirety by the registered staff member that notes/finds or performs an administration or dispensing medication error. The completed form will then be forwarded to the Director of Care for review. The Director of Care will then forward the incident report to the resident's physician for review and the Physician and Pharmacy Advisory Committee who will review all medication errors and adverse reactions if any and make recommendations to prevent further incidents.

A description of the incident, authored by the DOC, noted the licensee had concluded that there had been a "violation of medication administration policy by not administering medications [themselves], and then signed on the eMAR as administered by [RPN #106]". In an interview, the DOC advised that a medication incident report had not been completed. On a specified date, RN #120 indicated they had forgotten to complete the medication incident form as per policy.

RPN #106 left medication for a family member to administer; the RPN did not remain with the resident. In addition, upon discovery of the administration errors an incident report was not completed as per the licensee's medication policy. [s. 8. (1) (b)]

WN #2: 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. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

On a specified date and time, RPN # 106 mixed resident #001's medications with a drink and left them with a family member to administer during a meal. The family member questioned the large amount of liquid in which the medications were mixed, but indicated they would try to have resident #001 take them. Resident #001 refused to drink most of the liquid requiring that the family member approach RN #120 to advise that resident #001 had not received the correct dose of medication.

In an interview on September 19, 2018 RN #120 confirmed that there had been no impact on the resident as the on call physician ordered a one time dose of the missed medication be provided immediately following the incident.

The licensee failed to ensure that no person other than a physician, dentist, registered nurse or a registered practical nurse administered resident medications. [s. 131. (3)]

Issued on this 2nd day of October, 2018

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

Original report signed by the inspector.