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
Mar 4, 2020	2020_791739_0011	003448-20	Critical Incident System

Licensee/Titulaire de permis

Copper Terrace Limited
284 Central Avenue LONDON ON N6B 2C8

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

Copper Terrace
91 Tecumseh Road CHATHAM ON N7M 1B3

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

JULIE DALESSANDRO (739)

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 27 and 28, 2020.

The following intake was completed during the course of this inspection:
Log #003448-20 / CI #1115-000007-20 related to medication.

During the course of the inspection, the inspector(s) spoke with Registered Practical Nurse(s), the home's Nurse Practitioner, Associate Director of Clinical Services, Director of Clinical Services, and the resident.

During the course of this inspection the inspector(s) also conducted record reviews and observations relevant to the inspection.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **1 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. 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 has failed to ensure that drugs were administered to residents in

accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

On a specific date the home submitted Critical Incident (CI) report #1115-000007-20 to the Ministry of Long-Term Care regarding a medication incident involving resident #001. The CI stated that an order for a specific medication was not processed or scanned to pharmacy resulting in resident #001 missing their medication.

A record review of resident #001's clinical chart in Point Click Care (PCC) indicated that on a specific date, NP#101 was asked to assess resident #001 due to medical concerns that had lasted several days. NP #101 documented that they would like to rule out a specific diagnosis and ordered a certain medication to be taken for a specific number of days.

On a later date a physician's note in resident #001's progress notes stated that NP #101 was in and ordered the same medication for another specific number of days.

Another progress note stated that, NP #105 was in to follow up on resident #001's diagnosis and documented in part that the same medication was to be administered until the next assessment from the Nurse Practitioner or Physician with diagnostic testing included.

Record review of Hogan Pharmacy Prescriber Order Form from a specific date indicated that there was an order written by NP #105 which stated in part, to continue with the medication until lab results were available.

A review of resident #001's Medication Administration Record for a specific month indicated that several consecutive doses of the specific medication was not administered to resident #001.

A progress note on a specific date stated that the specific medication was extended however, this extension did not occur and resident #001 had been off therapy for several days.

During an interview with RPN #104, they stated that they were working the day that NP #105 had continued the specific medication for resident #001 however, they could not recall if they had scanned the order to pharmacy.

During an interview with Assistant Director of Clinical Services (ADOCS) #103, they stated that on a specific date NP #101 had stated to them that they had a concern regarding a medication order for resident #001. ADOCS #103 stated that NP #101 told them that on a specific date NP #105 had ordered a medication which was to have been continued until the next labs were obtained however, the order had not been processed. ADOCS #103 stated that they looked in PCC under the miscellaneous tab and it showed that the order for the specific medication was never uploaded to the pharmacy. ADOCS #103 indicated that resident #001 had missed several doses of the medication.

During an interview with the home's Director of Clinical Services (DOCS) #100, they stated that the specific medication was ordered for resident #001 but was never faxed to pharmacy so the resident did not receive the medication because the pharmacy did not get the order. DOCS #100 indicated that resident #001 missed several doses of their medication.

DOCS #100 acknowledged that resident #001 did not receive their specific medication by mouth once daily in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 4th day of March, 2020

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

Original report signed by the inspector.