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
Jun 23, 2020	2020_668543_0009	001925-20, 003724-20, 004604-20	Critical Incident System

Licensee/Titulaire de permis

Valley East Long Term Care Centre Inc.
c/o Jarlette Health Services 711 Yonge Street MIDLAND ON L4R 2E1

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

Elizabeth Centre
2100 Main Street Val Caron ON P3N 1S7

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

TIFFANY BOUCHER (543), DAVID SCHAEFER (757)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 27-29, 2020 (offsite) and June 1-4 (onsite)

The following intakes that were submitted to the Director were inspected during this inspection:

One intake, related to Medication Administration,
Two intakes, related to Falls.

A Follow-up inspection #2020_668543_0011, and a Complaint inspection #2020_668543_0010 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Director Of Care (Co-DOC), Staff Educator, Restorative Care Coordinator, Restorative Care Aide, Environmental Services Manager, Registered Nurse(s) (RN), Registered Practical Nurse(s) (RPN) and Personal Support Workers (PSW).

The Inspector also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents and policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication

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	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. 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 where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy/program, the strategy/program was complied with.

In accordance with Ontario Regulation (O. Reg.) 79/10, s. 48 (1) 1., and in reference to O. Reg. 79/10 s. 49 (1), the licensee was required to ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury was implemented in the home, and which provided strategies to monitor residents.

Specifically, staff did not comply with the home's policy "Resident Rights, Care and Services - Required Programs - Falls Prevention and Management - Program", last updated May 7, 2019. The policy stated that registered staff were required to, when a resident had fallen, have a specific assessment initiated if injury is evident and to initiate a specific assessment for all unwitnessed falls "unless resident is capable of reliably communicating that they did not hit their head".

Review of the home's specific assessment paper documentation identified that once initiated, the specific assessment records were required to be completed at specific time intervals. The specific assessment record was required to be completed at each of these intervals.

A) A Critical Incident System (CIS) report was submitted to the Director which indicated that resident #002 had a fall on a date in 2020. The report indicated that the fall was unwitnessed, and that on assessment the resident had complained of pain.

A progress note, indicated that the specific assessment had been initiated post-fall. A

progress note dated on a specific date in 2020, indicated that the resident had later been sent to hospital. A further progress note, indicated that the resident had then been transferred back to the home from the hospital with a diagnosis of an injury.

Inspector #757 reviewed the specific assessment documentation and identified that specific areas had not been completed:

B) A CIS report was submitted to the Director which indicated that resident #006 had a fall on a date in 2020.

An electronic progress note, indicated that a specific assessment had been initiated post-fall.

Inspector #757 reviewed the documentation on the specific assessment and identified that specific areas had not been completed:

C) Inspector #757 conducted a review of resident #017's electronic progress notes which identified that the resident had an unwitnessed fall on a date in 2019. The post-fall progress note identified that the specific assessment was initiated following the fall.

Review of resident #017's specific assessment record identified that while the specific assessment had been initiated, it had not been fully completed.

During an interview with the DOC, they stated that once initiated, staff were expected to complete all areas of the specific assessment. The DOC further indicated that when a resident had been transferred to hospital post-fall, the specific assessment was expected to be resumed upon their return, if the resident had returned within the specific assessment's required assessment intervals. [s. 8. (1) (a),s. 8. (1) (b)]

2. In accordance with Ontario Regulation (O. Reg.) 79/10, s. 114 (2), the licensee was to ensure that written policies and protocols were 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.

A Critical Incident System (CIS) was submitted to the Director on a date in, 2020, related to missing medication and medication administration discrepancies.

Inspector #543 reviewed investigation documents related to the incident(s), which

identified several separate incidents of medication administration discrepancies with different residents; where non-compliance was identified with the following Medication Managemant System policies:

i) “Resident Rights, Care and Services-Medication Management-Medication Administration Record” indicated that the registered staff shall document the administration of medications on the Medication Administration Record (MAR). Document the administration of the medication on the MAR by signing in the designated section. Failure to sign for a medication indicates the medication was not given and therefore, considered a medication error of omission.

One incident described that RPN #116 had signed for a specific medication but administered a different one to resident #003. On a date in 2020, RPN #116 documented that two tablets of a medication were administered at a specified time and again six hours later to resident #003. Only two tablets were documented in the MAR. On this same day, numerous medication sheets were found in the garbage ripped up. An interview document, indicated that RPN #116 knew what the purpose of the medication sheets were, and that they knew those sheets were legal documents and must be kept in the residents’ chart.

A second incident described that RPN #116 had signed for three administrations of a specific medication on the medication sheet for resident #011, however only signed for one dose as being administered on resident #011’s Medication Administration Record (MAR), two vials of a specific medication were unaccounted for. On another date, the RPN signed out two administrations of a specific medication and only signed for one administration documented on MAR.

A third incident described that RPN #116 had administered a specific medication to resident #007, with a note in the in the progress notes of the current status of the resident, the medication was not required according to the documentation. As well, there was documentation that indicated that a specific dose of a specific medication was administered at a specific time, and other notes indicating one administration was “Scratched off” stating inappropriate documentation, however the vial of the specific medication was signed out on the medication sheet. Discrepancy in documentation and/or administration.

Another incident described that RPN #116 had signed out two administrations of a specific medication on the medication sheet, but only signed one in the MAR for resident

#012.

A fifth incident described that for resident #009 there were two medication cards in circulation for a specific medication, and on a date in 2019, RPN #116 signed out medication on both medication cards. As well, RPN #116 had signed out with two different signatures. On two separate dates in 2019, RPN #116 signed for four tabs of a specific medication in the MAR but did not sign out the medication on the medication sheet. On another date in 2019, two tablets of a specific medication were signed out on the medication sheet, but only one tablet was signed in the MAR. On another date in 2019, one tablet of a specific medication was signed for on the medication sheet, but two tablets were noted as administered in the MAR. On another date in 2019, one tablet of a specific medication was signed as administered in the MAR, yet nothing was signed on the medication sheet. On a date in 2020, two tablets of a specific medication were signed for on the medication sheet, but only one tablet signed as administered in the MAR.

Another incident described that for resident #005, on a date in 2019, RPN #116 signed out two tablets of a specific medication on the medication sheet but only one tablet on the MAR. On a different date in 2019, the RPN signed out two tablets of a medication on the MAR but erased the medication on the medication sheet. On another date in 2019, two tablets were signed out on the medication sheet but only one was signed on the MAR. On a date in 2020, the RPN signed for two tablets on the MAR but only one tablet was signed on the medication sheet. On another date in 2020, two tablets were signed on the medication sheet but only one tablet was signed on the MAR.

A seventh incident described that resident #008 was ordered a specific dose of a specific medication to be administered at specific times as needed. On a date in 2019, RPN #116 signed out a dose of the medication on the medication sheet at four different times, but documented a different dose given in Point Click Care (PCC) and MAR at three different times. But only three were recorded in the MAR, and there was no wastage of the medication documented.

ii) “Resident Rights, Care and Services-Medication Management-Narcotics and Controlled Substances” indicated that the registered staff would retain the individual narcotic count sheet in the Controlled Substances and Administration Record binder or attached to the narcotic/controlled substance in the narcotic bin, this is at the discretion of the home and their preference. Record all narcotics administered on the Medication Administration Record.

One incident described that RPN #116 had signed for a specific medication but administered a different one to resident #003. On a date in 2020, RPN #116 documented that two tablets of a medication were administered at a specified time and again six hours later to resident #003. Only two tablets were documented in the MAR. On this same day, numerous medication sheets were found in the garbage ripped up. An interview document, indicated that RPN #116 knew what the purpose of the medication sheets were, and that they knew those sheets were legal documents and must be kept in the residents' chart

Inspector #543 reviewed a document dated on a date in 2020, that indicated RPN #116 was terminated as a result of their nursing practices that put the residents health and safety at risk.

Inspector #543 interviewed RPN #117 regarding the process for the administration of specific medications. The RPN indicated that they would remove medication from the drug cart, match the medication with the resident's MAR, they would then sign a drug record book on the sheet for the specific medication and then they would sign that the medication was dispensed on the MAR. Then the medication sheet related to that medication for the particular resident would be signed. RPN #117 indicated that on that date in 2020, they had noted that they had found some pouches of medication had been discarded in the garbage with medication remaining in the pouches. As well, they indicated that they had found medication sheets that had been torn and disposed of in the garbage.

Inspector #543 interviewed RN #118 regarding the process for the administration of specific medications. The RN indicated that they would sign on the MAR that the medication was administered. They indicated that the medication sheet also needed to be signed to ensure that the count was accurate.

The Inspector interviewed the DOC, who indicated that the registered staff member would record on the medication count sheet the medication that was being administered, as well as signing the MAR. They further indicated that there was a specific medication sheet for each resident who was prescribed a specific medication, and there was a unit sheet for counts as well.

Related to the incident that occurred on that date in 2020, the DOC indicated that RPN #117 had found an empty card of a specific medication for resident #003, as well as medication count sheets in the garbage. They indicated that the sheets were ripped up

and that they had taped them back together. The DOC indicated that they had noticed that it was consistently RPN #116 signing out those medications. Resident #003 was questioned, and was able to recall the colour, shape and type of medication they had been been given, and the resident indicated that it had not been the specific medication there were administered, but a different one.

Inspector #543 interviewed the Administrator who indicated that the investigation identified that most of the specified medications for residents were signed out on RPN #116's shifts. The indicated that they were able to confirm with resident #003 that they were not administered the medication indicated, but were administered a different medication, and that they had not been administered the medication specified since the previous summer. The investigation identified that RPN #116 had not followed College of Nurses of Ontario (CNO) standards or the home's policies related to their Medication Management System [s. 8. (1) (b)]

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 where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any strategy/program, the strategy/program is complied with, to be implemented voluntarily.

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. (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 that drugs were administered to residents in accordance with the direction for use specified by the prescriber.

A CIS report was submitted to the Director on a date in 2020, related to missing medications and medication administration discrepancies.

Inspector #543 reviewed investigation documents related to the incident(s), which identified several separate incidents of medication administration discrepancies.

One incident described that resident #004 was ordered a specific dose of a specified medication for a specific reason. RPN #116 administered the medication to resident #004 who had not required the medication at the time, the medication administration was not required.

Another incident described that RPN #116 had administered a specific medication to resident #007, with a note in the progress notes of the current status of the resident, the medication was not required according to the documentation.

A third incident described that resident #010 was ordered a specific dose of a certain medication as needed. On a date in 2020, resident #010 was administered three doses of the specific medication, with no documentation of the resident displaying the need for the medication.

Inspector #543 reviewed the “Resident Rights, Care and Services-Medication Management-Administration of Medication including PRN Medications” policy. The policy indicated that pro re nata (PRN) medications shall only be administered for the purpose in which they were ordered.

Inspector #543 interviewed RN #118 who indicated that when administering medications, all rights of administration should be followed as per standard and sign on the medication administration record that the drug was given to the resident.

The Inspector interviewed the DOC who indicated that the registered staff member must ensure that all rights of administration were followed and that the staff member should double check the order.

Inspector #543 interviewed the Administrator who indicated that the registered staff member would compare the medication to the order, then sign that the medication was administered on the administration record. [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 direction for use specified by the prescriber, to be implemented voluntarily.

Issued on this 25th day of June, 2020

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

Original report signed by the inspector.