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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 18, 2016	2016_235507_0007	017124-15	Complaint

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE ROUGE VALLEY
551 Conlins Road TORONTO ON M1B 5S1

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

STELLA NG (507)

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): February 16, 17, 18, 19, 22, 23, 24, 25, 26, 29, March 1, 2, 3, 4, 7, 8 and 9, 2016.

This Complaint Inspection is related to a complaint regarding the administration of medication, plan of care regarding referral to Community Care Access Centre (CCAC) and notifying the pharmacy service provider. This inspection occurred concurrently with the Resident Quality Inspection (RQI) report #2016_353589_0005.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Practical Nurses (RPNs), Pharmacy Manager and family member.

During the course of the inspection, the inspector(s) conducted observation and reviewed resident and home records, and relevant policies.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication

During the course of this inspection, Non-Compliances were issued.
- **3 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	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. 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 are administered to residents in accordance with the directions for use specified by the prescriber.

Review of the progress notes of resident #003 revealed the resident was hospitalized for five days during an identified period.

Review of the Discharge Summary from the hospital on the discharge date revealed one of resident #003's discharge medications was an identified medication for two more days. Review of the Prescription & Discharge Summary from the hospital on the same date revealed new or changed treatment for resident #003 was the above mentioned identified medication for two days.

Review of resident #003's Best Possible Medication History (BPMH) Reconciliation/ Admission Orders on the identified date the resident returned to the home revealed the above mentioned medication was not listed.

Review of the progress notes of resident #003 revealed three days after the resident returned to the home from the hospital, the physician discovered the above mentioned medication was not ordered for the resident as indicated on the Discharge Summary and the Prescription & Discharge Summary from the hospital.

Review of the Original Physician's Orders and the electronic Medication Administration Record (eMAR) for the month resident #003 was hospitalized revealed the above mentioned medication was ordered on the day the physician discovered it was not ordered, and resident #003 received the first dosage of the above mentioned medication the following day.

Interview with staff #102 revealed he/she completed the BPMH Reconciliation/ Admission Order for resident #003 when the resident returned from the hospital, and the process required reviewing all discharge summary notes from the hospital and obtaining orders from the resident's home physician. Staff #102 confirmed he/she missed transcribing the above mentioned medication onto the BPMH Reconciliation/ Admission Order during the process.

Interview with staff #145 revealed he/she reviewed the BPMH Reconciliation/ Admission Order for resident #003 the next day. Staff #145 confirmed he/she was not aware of the above mentioned medication order from the hospital at the time of the review process.

Interview with staff #105 revealed that four days after resident #003's return from the hospital, he/she became aware of resident #003 did not receive the above mentioned

medication since returning from the hospital, upon receiving the Medication Incident Report from the Pharmacy Service Provider. Staff #105 further revealed he/she conducted the investigation, and interviewed the three involved staff. Staff #105 confirmed the above mentioned medication was not ordered and administered to resident #003 as prescribed by the physician at the hospital when the resident returned from the hospital. [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.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 121. Every licensee of a long-term care home shall ensure that a system is developed for notifying the pharmacy service provider within 24 hours of the admission, medical absence, psychiatric absence, discharge, and death of a resident. O. Reg. 79/10, s. 121.

Findings/Faits saillants :

1. The licensee has failed to ensure that a system is developed for notifying the pharmacy service provider within 24 hours of the medical absence and discharge of a resident.

Review of the progress notes of resident #003 revealed the resident was sent to the hospital on an identified date, and was officially discharged from the home 12 days later.

Interview with resident #003's family member revealed invoice from the Pharmacy Service Provider was sent to the resident for medication refills on two separate dates after the resident was sent to the hospital.

Record review of resident #003's Patient Medical History Report for the identified month the resident was sent to the hospital, and interview with the Pharmacy Manager of the Pharmacy Service Provider, revealed medications were refilled for the resident on two identified dates during the period the resident was in hospital. Record review of the Daily Communication Form of the Pharmacy Service Provider and interview with the Pharmacy Manager revealed the Pharmacy Service Provider received notification from the home three days after resident #003 was discharged from the home.

Review of the Pharmacy Service Provider's Pharmacy Policy & Procedure Manual for LTC Homes policy "Hospitalization of Residents" (policy #7-4), indicates pharmacy must be notified of resident admission to hospital, for medical or psychiatric absence within 24 hours, and weekly medications will be stopped. The policy further indicates that if home receives a weekly shipment of medications for a resident in hospital, the medications must be returned promptly and the pharmacy notified that the medications are being returned and the reason why.

Interview with staff #123 revealed notifying the pharmacy of a resident's medical or psychiatric absence was never done. Staff #123 further revealed any unused medications were placed in the surplus medication box, and would be disposed by the pharmacist.

Interview with staff #105 revealed the home's practice was to notify the pharmacy of the resident's medical absence when a resident has been admitted to the hospital for over four days. Staff #105 confirmed he/she was not aware of the requirement of notifying the pharmacy within 24 hours of the medical absence and discharge of a resident. [s. 121.]

WN #3: 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).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and

maintain the resident's health.

In accordance with the definition identified in section 1 of the Regulation 79/10, medication incident means a preventable event associated with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a prescription, and includes,
(a) An act of omission or commission, whether or not it results in harm, injury or death to a resident, or
(b) A near miss event where an incident does not reach a resident but had it done so, harm, injury or death could have resulted.

Review of the progress notes of resident #003 revealed the resident was hospitalized for five days during an identified period.

Review of the Discharge Summary from the hospital on the date the resident was discharged revealed one of resident #003's discharge medications was an identified medication for two more days. Review of the Prescription & Discharge Summary from the hospital of the same date, revealed new or changed treatment for resident #003 was the above mentioned medication for two days.

Review of resident #003's Best Possible Medication History (BPMH) Reconciliation/ Admission Orders on the date the resident returned to the home revealed the above mentioned medication was not listed.

Review of the progress notes of resident #003 revealed that on an identified date, the physician discovered the above mentioned medication was not ordered for the resident as indicated on the Discharge Summary and the Prescription & Discharge Summary from the hospital three days earlier.

Review of the Original Physician's Orders and the electronic Medication Administration Record (eMAR) for an identified month for resident #003 revealed the above mentioned medication was ordered three days after the resident was discharged from the hospital, and resident #003 received the first dosage of the medication the following day.

Review of an identified Medication Incident Report and interview with staff #105 confirmed the medication incident report involved resident #003 did not include a record of the immediate actions taken to assess and maintain the resident's health as required. [s. 135. (1)]

2. The licensee has failed to ensure that a written record is kept for the review, analysis, corrective action taken as necessary for all medication incidents and adverse drug reactions.

Review of the Professional Advisory Committee meeting minutes on two identified dates and interview with staff #105 confirmed the home did not have a written record of the review and analysis of the medication incidents and adverse drug reactions if any, as well as any corrective action is taken as necessary by the licensee. [s. 135. (2)]

3. The licensee has failed to ensure that a written record of the quarterly review of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, and any changes and improvements identified in the review are implemented is kept.

Review of the Professional Advisory Committee meeting minutes on two identified dates and interview with staff #105 confirmed the home did not have a written record of the quarterly review of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, and any changes and improvements identified in the review are implemented. [s. 135. (3)]

Issued on this 26th day of April, 2016

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

Original report signed by the inspector.