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 10, 2020	2020_822613_0009	001176-20, 001452-20, 002828-20	Critical Incident System

Licensee/Titulaire de permis

F. J. Davey Home
733 Third Line East Sault Ste Marie ON P6A 7C1

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

F. J. Davey Home
733 Third Line East SAULT STE. MARIE ON P6A 7C1

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

LISA MOORE (613)

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 24 - 28, 2020 and March 2, 2020.

The following intakes were inspected during this Inspection:

Two Critical Incident reports and that were submitted to the Director regarding resident falls resulting in an injury and transfer to the hospital;

One Critical Incident report that was submitted to the Director regarding a medication error resulting in a resident transfer to the hospital.

A concurrent Complaint Inspection #2020_822613_0008 was also conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Administrator (EADM), Executive Director of Care (EDOC), Directors of Care (DOCs), Physiotherapist (PT), Social Worker (SW), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The Inspector also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed video surveillance, personnel files, health care records, internal investigation files and policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Inspector #613 reviewed a Critical Incident (CI) report that was submitted to the Director, identifying resident #003 received medications that had not been prescribed for them, on a specific day. The CI report indicated that RPN #113 administered medications according to the name labelled on resident #003's pajamas; however, the pajamas did not belong to resident #003. As per the CI report, RPN #113 administered medications to resident #003, that were prescribed for resident #004, in error, and as a result of the medication administration error, resident #003 was transferred to the hospital.

A review of the licensee's policy titled,"Medication Management" (RC-16-01-07) last updated August 2019, identified that two resident identifiers were required prior to a registered nurse administering medications. The registered nurse was to verify the identification of all residents using two of the following acceptable client identifiers prior to the provision of any medication, treatment or procedure:

a) Current resident picture from (Medication Administration Record / Treatment Administration Record) MAR/TAR;
b) Resident Identification bracelet;
c) Verbal confirmation from the resident who was capable of identifying their name without prompting from staff; and
d) A staff member who had a long-term relationship with the resident who could validate resident identification.

The procedure further stated that a registered nurse was to administer medications following the (eight) 8 "Rights" of medication administration, which included a) Right resident and b) Right drug.

A review of the home's internal investigation file identified that the medication error was a

result of RPN #113 not looking at the picture of the resident on the electronic medication administration record (eMAR) and only identifying the resident by the name labelled on their pajamas.

During interviews with RPN #105 and #106, they stated that two resident identifiers were required prior to administering medications to all residents and both RPNs were able to state the acceptable resident identifiers to the Inspector, as per the licensee's Medication Management policy.

During interviews with the Executive Director of Care (EDOC) and Director of Care (DOC) #101, they stated that RPN #113 failed to identify the resident appropriately and as a result administered medication to resident #003, that were not prescribed for them. Both confirmed that RPN #113 did not follow the licensee's Medication Management policy. [s. 131. (1)]

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

Issued on this 11th day of March, 2020

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

Original report signed by the inspector.