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 24, 2020	2020_815623_0007	023947-19	Complaint

Licensee/Titulaire de permis

The Corporation of the City of Peterborough and The Corporation of the County of Peterborough
c/o Fairhaven 881 Dutton Road PETERBOROUGH ON K9H 7S4

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

Fairhaven
881 Dutton Road PETERBOROUGH ON K9H 7S4

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

SARAH GILLIS (623)

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 11-14, 20, 21 and 24, 2020

During the course of this inspection the following intake was inspected:

A Complaint related to resident care, medications, complaints and falls.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care, Resident Care Supervisor (RCS), Resident Care Managers (RCM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and families.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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 Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10. s. 114 (2) the licensee was required to ensure that written policies and protocols were developed for the medication management system to ensure the accurate dispensing and administration of all drugs used in the home.

Specifically, staff did not comply with the licensee's policy Medical Pharmacies "Readmission of Resident from Hospital" 7-5 and Fairhaven Policy #RCM-N-910 "Processing Medical Orders".

The Readmission of Resident from Hospital policy indicated:

Procedure

4. Orders are written on the Best Possible Medication History (BPMH) Reconciliation / Admission Orders or equivalent and communicated to pharmacy.
5. Ensure MAR accurately reflects all new and changed orders.
6. Review readmission orders carefully especially medications on hold during resident's stay in hospital. Hold orders will need to be discontinued or reactivated.
7. Ensure medications are available and labeled, to reflect current physician orders.
8. Remove any discontinued medications, place with surplus medications and document appropriately.

The Processing Medical Orders policy indicated:

All medical orders will be double checked by registered staff. This includes three-month reviews.

The policy indicated that medical orders including three-month reviews, will be processed in the following manner:
-When new medical orders are entered onto the chart the RED and BLUE flags are pulled up indicating that a new order had been received and needs to be processed.
- Nurse initials in the first check box. Upon completion of the first check the red flag is put down.
- RN/RPN coming in the following shift will check orders thoroughly to make sure all orders have been processed. When this is done, initial the second check box. Upon completion of second check the blue flag is put down.

A complaint was received by the Director identifying concerns related to the care of resident #002. During the initial phone call with Inspector #623, the complainant indicated that they were notified by the home on a specified date that a medication incident had occurred involving resident #002 not receiving specific medications for three days after being readmitted from the hospital.

Review of the clinical records for resident #002 indicated the following:

On a specified date and time resident #002 was transferred back to the home following a hospital admission. RN #111 created the Best Possible Medication History (BPMH) using the orders received from hospital and the orders prior to transfer to hospital. RN #106 completed the second check of the BPMH, received physician orders for resident #002 and notified RPN #112 of the readmission orders. RPN #112 failed to initiate the first check of the readmission orders for resident #002 to ensure that the Medication Administration Record (MAR) accurately reflected all new and changed orders. As a result of the medication orders not being processed, RPN #112 administered the incorrect dose of a specified medication to resident #002 on an identified date. RPN #116 worked the following shift, failed to initiate the first check of the medication orders - BPMH and failed to perform the night shift duty of checking for medication orders.

On two identified dates, RPN #113 administered the incorrect dose of a specified medication along with other discontinued medications, to resident #002. RPN #113 also failed to initiate the first check of the medication orders – BPMH for checking new medication orders. RPN #115 administered the incorrect dose of a specified medication

as well as other discontinued medications to resident #002. RPN #115 also failed to complete the first check of the medication orders – BPMH checking of new medication orders. RPN #114 failed to initiate the first check of the medication orders – BPMH and failed to perform the specific shift duty of checking for new medication orders.

On a specified date, RPN #114 discovered that the re-admission orders for resident #002 had not been processed, resulting in medications not being administered as prescribed and multiple medication errors. The incident was reported to the RN Supervisor.

During an interview with Inspector #623, RN #103 indicated that there has been an ongoing issue with physician orders not being second checked in a timely manner. The RN indicated that staff had received education as well as reminder memos to check for new orders and to use the flagging system in the chart to identify a new order that needs checking. RN #103 indicated that there was an incident involving resident #002 when they returned from hospital and their readmission orders were not processed properly. There were changes to the resident's medication orders which resulted in resident #002 receiving the incorrect dose of a specified medication for three consecutive days. The RN indicated that the incident was reported, and a medication incident form was completed. There was no negative effect on the resident as a result of the incorrect dose of the specific medication and they were also being monitored during that time which would have alerted staff to any change. The physician was notified and did not have any concerns. The SDM was also notified of the error. RN #103 indicated that there are policies for processing orders through Medical Pharmacies and Fairhaven. The expectation is that the nursing staff would follow the policy Readmission of Resident from Hospital and Processing Medical Orders, when a resident returns to the home following a hospital admission.

During an interview with Inspector #623, the Director of Care indicated that the expectation of the licensee is that when a resident is admitted or readmitted to the home, the registered staff will obtain the best possible medication history, then follow the policy Medical Pharmacies #7-5 Readmission of Resident from Hospital and Fairhaven's policy RCM-N-910 Processing Medical Orders. The DOC indicated that there were multiple medication incidents involving resident #002 when they returned from hospital and the orders were not processed according to the policy.

The licensee failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with. Specifically, staff did not comply with the licensee's policy Medical

Pharmacies “Readmission of Resident from Hospital” #7-5 and Fairhaven Policy #RCM-N-910 “Processing Medical Orders”. [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 by ensuring that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied with, in accordance with O.Reg 79/10. s.114 (2) medication management system to ensure the accurate dispensing and administration of all drugs used in the home, 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 has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On a specified date, resident #002 was readmitted to the home following a hospital admission. Readmission medication orders were received by the home which included specific identified medication changes.The orders were not processed until several days later, which included adding and removing specific medications as prescribed to the electronic medication administration record (eMAR). This resulted in resident #002 receiving three specific medications that were not prescribed as well as the incorrect dose of two specific medications on three identified dates.

During an interview with Inspector #623, RN #103 indicated that there is a policy for processing orders through Medical Pharmacies. The expectation is that the nursing staff

would follow the policy when a new order is received. RN #103 indicated that new orders should be first checked the day that they are received and second checked within 24 hours. The RN indicated that if an order is received during business hours, prior to 4:00 PM then the pharmacy will input the order into the electronic system. If it is received after 4:00PM or outside of business hours, then the nurse who receives the order is expected to input the order into the electronic system and notify the after-hours pharmacy for emergency delivery if the medication is required before the next business day. RN #103 indicated that on the identified date resident #002 returned from hospital after pharmacy business hours and it would have been the responsibility of the nurse to input the medication changes into the electronic system.

During an interview with Inspector #623, the Director of Care indicated that the expectation of the licensee is that when a resident is admitted or readmitted to the home, the registered staff will follow the policy Medical Pharmacies #7-2 Medication Reconciliation to obtain the best possible medication history. The DOC indicated that the initial orders should be transcribed by the nurse, once the orders were verified by the nurse with the physician, then the orders would then be first and second checked by two different nurses, RN or RPN. The DOC indicated that there was a medication incident involving resident #002 when they returned from hospital on a specified date and the orders were not processed according to the policy. The DOC indicated that the initial orders were not first and second checked until three days later. For a specific identified period of time, resident #002 received multiple medications that were not prescribed, as well as the incorrect dose of medications specific, that were prescribed.

The licensee failed to ensure that drugs are administered to residents 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 by ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaints that have been received concerning the care of a resident or the operation of the home are immediately forwarded to the Director.

A complaint was received by the Director, which indicated that Substitute Decision Maker (SDM) for resident #002 had submitted a written complaint to the home by email to Resident Care Manger (RCM) #107 on a specified date, that identified concerns regarding the care of resident #002.

Inspector #623 was informed that Resident Care Manager #107 is not available for interview during this inspection.

During an interview with Inspector #623 the Executive Director (ED) indicated that a complaint log is maintained in the home in accordance with the complaints policy. The ED provided Inspector #623 with access to the electronic document. It was identified that the complaint from resident #002's SDM was recorded in the log. The written complaint was acknowledged on a specified date, when a written complaint was received from the SDM by email to Resident Care Manager (RCM) #107 on an identified date. The ED indicated that a care conference was scheduled and all concerns were addressed, the complaint was considered closed following that meeting. The ED indicated that there has been no further verbal or written complaints brought forwards by the SDM since that time. The ED indicated that a copy of the written complaint was not submitted to the Director along with the response to the complainant. The ED indicated that this was an oversite.

The licensee failed to immediately forward to the Director, a written complaint that had been received concerning the care of resident #002. [s. 22. (1)]

Issued on this 29th day of June, 2020

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

Original report signed by the inspector.