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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 8, 2018	2017_687607_0024	016197-17, 022042-17, 023089-17, 028736-17, 028915-17	Critical Incident System

Licensee/Titulaire de permis

Regional Municipality of Durham
605 Rossland Road East WHITBY ON L1N 6A3

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

Fairview Lodge
632 Dundas Street West P.O. Box 300 WHITBY ON L1N 5S3

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

JULIET MANDERSON-GRAY (607)

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): December 12, 13, 14, 15, 18, 19, 20 and 21, 2017

A Complaint inspection (Inspection #2017_687607_0023) (Log # 024119-17) was completed concurrently during the Critical Incident inspection and non-compliance was identified for the Complaint inspection and was issued under inspection #2017_687607_0024 related to s. 6 (10) (b) for resident #015.

A Follow up inspection (Log #'s 017741-17, 017841-17) was completed concurrently during this Critical Incident inspection (see inspection #2017_687607_0022) related responsive behaviours and plan of care, specific to clear directions, non-compliance was identified for the Follow up inspection and was issued under inspection #2017_687607_0024.

In addition, the following logs were reviewed and inspected during this Critical incident Inspection:
1) Log #: 028736-17, regarding a missing or unaccounted for controlled substance.
2) Log #: 022042-17, regarding an incident that caused an injury for which the resident was taken to hospital.
3) Log #: 016197-17, regarding an alleged resident to resident abuse.
4) Log #: 023089-17, related to an alleged resident to resident abuse.
5) Log #:028915-17, regarding a resident that was missing for less than three hour.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Clinical Resource Nurse (CRN), Resident Care Coordinators (RCC), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), families and residents.

During the course of the inspection, the inspector observed staff to residents interactions and provision of care, review relevant home records, relevant policies and procedures and resident health records.

The following Inspection Protocols were used during this inspection:

Critical Incident Response
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **4 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

Related to Log # 022042-17 involving resident #001.

A CIR was submitted to the Director on an identified date and time, for an incident related to a fall that resulted in an injury to resident #001. The CIR indicated that resident #001 was being provided continence care and was also being transferred by PSW #111 and #112 via a mechanical lift. The PSWs indicated that the resident was left unattended to provide privacy when the resident fell to the floor.

A review of resident #001's Resident Assessment Protocol (RAPS) with identified dates, prior to the residents' fall and after the residents' fall, indicated resident #001 had

decreased balance when seated due to an identified diagnoses.

A review of the written plan of care that was in place at the time of the incident, related to toileting and transfer indicated resident #001 required two staff assistance with transferring with a mechanical lift. There was no documented evidence in the written plan of care to indicate that the resident required support during continence care.

Both PSWs #111 and #112 indicated that the resident had a diagnosis that would requires the resident to be supported while seated. PSW #112 indicated that both PSWs had transferred resident #001 to provide continence care. PSW #111 was turning on the tap by the sink and began moving the mechanical lift away from the resident #001, at the same time. PSW #112 indicated he/she was standing beside the resident, when the resident toppled over sideways and fell on to his/her left side. PSW #112 further indicated that staff would normally transfer resident #001, by leaving the resident seated by him/herself during continence care to provide the resident with privacy. The PSW indicated that they had not got to this point, when the resident fell to the floor.

During interviews on two separate dates, both RPN #113 and RN #134 indicated that at the time of the incident of the resident falling, both PSWs #111 and #112 had indicated that they left resident #001 unattended to provide him/her with privacy, when the resident fell to the floor. Registered Practical Nurse #113, indicated that the PSWs should not have left resident #001 unattended as the resident required support.

On an identified date during an interview with the Physiotherapist (PT) #106, indicated that he/she was able to review resident #001's clinical health records and further indicated that there was no referral to the PT related to transferring since admission, but the resident had always used a mechanical lift for transfers.

The written plan of care for resident #001 did not set out the planned care for the resident, specifically related the written care plan failed to indicate that the resident required support during continence care due to an identified diagnosis [s. 6. (1) (a)]

2. Related to resident #002 and #019:

Resident #002 had diagnoses that included Cognitive Impairment.

Resident #019 and resident #002 resided on the same home area.

A review of the progress notes for resident #002 indicated the resident had one incident where the resident sat at the table where resident #019 usually sits and would not move even with staff interventions.

A review of the written plan of care for resident #002, indicated there were interventions in place related to the use of identifiers and seating plan in the dining area, for resident #002.

During an interview, RPN #103 indicated that resident #002 now sits at a table in the dining room by him/herself and further indicated that the resident had identifiers in place to indicate where he/she sits.

During an interview, PSW #107 indicated that not being aware of any identifiers that would assist resident #002 of where to sit in the dining room.

During another interview, RPN #103 confirmed identifiers were not included in resident #002's current written plan of care.

During an interview, the Resident Care Coordinator (RCC) #108 indicated that the expectation was that interventions related to resident #002 should be included in the written plan of care.

The written plan of care for resident #002 did not set out the planned care for the resident, specifically related to Personal Support Workers were not aware of identifiers that would assist the resident of where to sit in the dining room as well as the plan of care did not include interventions related to the identifiers. [s. 6. (1) (a)]

3. The licensee has failed to ensure that when the resident was reassessed, the plan of care was reviewed and revised at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Related to Log # 023089-17 involving residents #001, #017 and #018:

A CIR was submitted to the Director on an identified date for an incident related to an alleged resident to resident abuse. The CIR indicated that resident #017 was witnessed in residents #001's room exhibiting responsive behaviours towards the resident. The CIR also indicated that same date resident #018 had also indicated that resident #017 approached him/her while using his/her mobility aid and exhibited responsive behaviours

towards the resident.

During interviews, resident #001 and #018, both indicated having no recollection of the above identified incidents. All three residents had diagnoses that included cognitive impairments.

A review of resident #017's current written plan of care related to responsive behaviours, indicated there was an identified intervention in place that would alert staff of when the resident leave his/her room or when other residents enter.

On an identified date and time, the Inspector observed that the identified intervention was not in place for resident #017.

During an interview, both PSW #123 and RPN #121 indicated the identified intervention for resident #017 was no longer in place.

During an interview, RCC #108 indicated that the expectation was that resident's written plan of care be updated when the resident conditions or interventions changed.

When resident #017 was reassessed, the plan of care was not reviewed, when the resident's care needs change or care set out in the plan is no longer necessary, specifically related to the written plan of care indicated that the resident uses an identified intervention, when interviews with staff and observations indicated the intervention was no longer in place. [s. 6. (10) (b)]

4. Related to Log #016197-17 involving resident #002 and #003:

Resident #002 had diagnoses which included Cognitive Impairment.

During observations of resident #002's room on two identified dates indicated the resident room was noted to have lingering offensive odours.

During interviews, both PSW #110 and RPN #103 indicated that resident #002 had an identified responsive behaviour that caused lingering odours. Registered Practical Nurse #103 further indicated there were no interventions in the written plan of care to address how staff were to manage this behaviour.

During an interview, the Resident Care Coordinator (RCC) #108, indicated that the

expectation was that interventions related to resident #002 should be included in the care plan.

When resident #002 was reassessed, the plan of care was reviewed, but was not revised at any other time when the resident's care needs change, specifically related to the resident written plan of care did not include interventions related to resident #002 identified responsive behaviours. [s. 6. (10) (b)]

5. Related to Log # 017741-17 involving resident #007:

Resident #007 had diagnoses which included cognitive impairment and risk for falls:

A review of the current written plan of care indicated that resident #007 had six interventions in place related to falls.

A review of the flow sheets that the Personal Support Workers uses for documentation, indicated there were three identified interventions in place related to falls.

On an identified date, the Inspector observed a white board with care symbol for resident #007; there was no documented evidence on the white board next to care symbol to indicate one of the identified fall intervention located on the flow sheet was being used for resident #007.

During interviews, both Personal Support Worker #142 and Registered Practical Nurse (RPN) #143 indicated that resident #007's identified fall prevention intervention, located on the flow sheets was no longer in use.

During an interview, with Resident Care Coordinator (RCC) #108, indicated that registered staff are responsible for updating written plan of care and further indicated that the licensee expectation was that written plan of care be updated and kept current.

When resident #007 was reassessed, the plan of care was reviewed, but was not revised at any other time when the resident's care needs change or care set out in the plan was no longer necessary, specifically related to the flow sheets indicated the resident used identified fall prevention interventions, while interviews with staff indicated the resident no longer use these. [s. 6. (10) (b)]

6. Related to Log #024119-17 involving resident #014 and #015:

Resident #016 was cognitively well.

Resident #015 had diagnoses which included cognitive impairment.

During an interview, resident #015 indicated that not being able to recall having any altercation with any residents in the home.

During interview, with resident #016, the resident indicated that resident #015 threw beverages at him/her twice.

A review of resident #016's progress notes over a five month time period, indicated that there were two occasions where resident #015 threw beverages at resident #016 on two separate identified dates.

A review of resident #015's written plan of care in place at the time of the inspection related to responsive behaviours, indicated the resident had several interventions in place including intervention to address the behaviour that was directed towards resident #016.

During an interview, PSW #144 and RPN #119 indicated that resident #015 had responsive behaviours that was directed towards resident #016, and further indicated an intervention was put in place to address the residents behaviour and this intervention had since been discontinued.

During an interview, RCC #108 indicated that the expectation was that the written care plan be changed as the resident conditions changed.

When resident #015 was reassessed, the plan of care was reviewed, but was not revised at any other time when the resident's care needs change or care set out in the plan was no longer necessary, specifically related to resident #015 written care plan indicated the resident had an identified intervention in place, when interviews with staff indicated this intervention was no longer in place. [s. 6. (10) (b)]

7. The licensee has failed to ensure that if the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, have different approaches been considered in the revision of the plan of care.

Related to Log # 022051-17 involving resident #002:

A CIR was submitted to the Director for an incident related a resident being missing for less than three hours. The CIR indicated resident #002 had multiple incidents of exiting the LongTerm Care home building through the front entrance.

A review of resident #002's clinical health records indicated the resident had diagnoses that included cognitive impairment.

A review of resident #002 written plan of care that was currently in place, indicated the resident had several intervention in place related to an identified responsive behaviour.

A review of resident #002's progress notes for an identified month in 2017, indicated that on four identified dates, and at five identified times, resident #002 exited the LongTerm Care home, through the front entrance while visitors were entering the building.

During an interview, Resident Care Coordinator #108 indicated at the time of the incident resident #002 had a device in place that would alert staff that the resident was exiting the building, and also indicated the device did not prevent the resident from exiting when visitors were entering/exiting the building. The RCC also indicated that with each incident of the resident exiting the building, the resident had one to one nursing staff providing supervision to the resident. The RCC further indicated to the Inspector that at the time of the incident involving resident #002, the interventions related to one to one nursing supervision and alert device system that was in place for resident #002 was not effective, in preventing resident #002 from exiting the LongTerm Care home.

When resident #002 was reassessed, the plan of care was not revised because care set out in the plan had not been effective, different approaches had not been considered in the revision of the plan of care, specifically related to resident #002 had an alert system in place and one to one nursing supervision, that were not effective in preventing the resident from exiting the building. [s. 6. (11) (b)]

8. Related to Log # 024119-17 involving residents #014, #015 and 016:

Resident #016 was cognitively well.

Resident #014 and #015 had diagnoses which included Dementia.

On two identified dates and times, the Inspector observed a barrier across resident #016’s door, with an alert device attached to it. The Inspector removed the barrier and the alert device did not activate.

A review of resident #016’s current written plan of care related to responsive behaviours indicated there was intervention in place that indicated that alert device was to deter other residents of entering resident #016's room.

During interviews, PSW #144 and RPN #188, both indicated that resident #014 had responsive behaviours of aggression that was directed towards resident #016, the PSW also indicated that resident #015 would sometime pass by resident #016’s door and rip the barrier from the door on purpose. PSW #144 further indicated that there was an alert device attached to the barrier of resident #016’s door that would alert staff when the residents were entering the resident #016's room. The Inspector and the RPN went to the resident’s door and tried activating the device and it did not function. The RPN indicated not being aware that the device was not functioning.

During an interview, RCC #108 indicated that the licensee expectation was that when a resident had a device in place, the device should be functional.

When resident #016 was being reassessed, the plan of care was not revised because the care set out in the plan had not been effective, and different approaches had not been considered in the revision of the plan of care, as resident #016 had an intervention of an alert device attached to the barrier across resident #016's door to alert staff of when residents were entering resident #016's room did not function. Interview with staff also indicated that they were not aware that the device attached to the barrier across resident #016's door was not functioning or for how long it was not functioning for. [s. 6. (11) (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 ensuring that when residents were reassessed and the plan of care was reviewed, the plan of care was revised at any other time when the resident's care needs change or care set out in the plan was no longer necessary, specifically related to #017 related to alert device, resident #002 related to an identified responsive behaviour, resident #007 and fall interventions, and resident #015 related to an identified intervention, to be implemented voluntarily.

WN #2: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Under O. Reg. 79/10, s. 114 (2), The licensee shall ensure that written policies and protocols are 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.

Related to Log #028736-17 involving resident #013:

A review of the home's policy Monitored Medications (Narcotics controlled and controlled

like drugs) policy #INTERD-03-03-10 dated September 16, 2015 (pgs 2-5) directs:

Administration - monitored medications:
3) Nurses will also sign on the "individual Monitored Medication Record" each time a monitored medication is administered. Documentation will include date, time, blister number(s), signature of nurse, amount given, amount wasted and quantity remaining.
5) The effect of the as needed (PRN) medication should be documented on the reverse side of the Medication Administration Record (MAR) sheet once sufficient time has passed.

Shift change Narcotic Count
1) At the change of each shift, two nurse (one from each shift involved) must count the remaining monitored medications on either shift change Monitored Drug Count Combined individual Monitored Medication Record with shift Count
2) As part of the shift count both nurses are required to count the remaining monitored medications including verification that all blister packs are intact and a review of medications dispensed during the outgoing shift.
3) Both nurses confirmed that the actual quantity of medications is the same as the amount recorded on the "Individual Monitored Medication Record".
4) Both nurses are responsible to ensure the date, time and quantity of medication and their signatures are recorded either on the "Shift Change Monitored Drug Count" or "Combined Individual Monitored Medication Record with Shift Count form".
5) All discrepancies of monitored medications must be reported immediately to the Director of Care/Resident Care Coordinator/delegate.

Care and Control of Medication Cart Keys and Narcotic and Controlled Medication Keys

2) Once the shift change narcotic and controlled medication count is completed, the keys and accountability of their care and control will be transferred.

Reporting of Monitored Medications Discrepancies
3) If the discrepancies remains unresolved, immediately notify the Resident Care Coordinator/DOC) (during regular hours) or the senior staff Member on call (if applicable).

A CIR was submitted to the Director for an incident at an identified date and time. The CIR indicated that an identified controlled substance count revealed that a scheduled dose of medication was unaccounted for.

During an interview, RPN #121 indicated he/she worked on the shift prior to the date the medication was unaccounted for, and earlier that shift resident #013 was agitated, at which time the schedule dose medication was administered, as the resident did not have an order for as needed (PRN) dose of the medication. The RPN indicated forgetting to document on the Medication Administration Record as well as the resident's individual narcotic count sheet that the identified medication was given, as the RPN had gotten distracted. The RPN also indicated not performing the narcotic count with the RPN on the oncoming shift.

During an interview, RPN #126 indicated that the date of the incident he/she had received the keys for the medication cart from RPN #121. RPN #126 indicated he/she did perform the narcotic count by him/herself and noticed that an identified medication for resident #013 was unaccounted for, and notified RN #128, who had contacted RPN #121 at home. RPN #126 indicated that RN #128 also completed a medication incident report that date. During further interview RPN #121 indicated that RN #128 did contact him/her at home to ask about another resident's medication, but did not ask about resident #013's unaccounted for medication. RN #128 was not available for an interview as he/she was no longer working at the Long term Care home. RPN #126 indicated that he/she went ahead and gave resident #013 a second dose of the identified scheduled medication, as there was no documented evidence by RPN #121 indicating that resident #013 had received the same medication earlier that shift.

During an interview, the Manager of Nursing Practice (MNP) indicated learning of the Medication Incident three days later. MNP further indicated that the expectation related to the medication incident was that RPN #121 should have documented why it was important that the identified medication was given to resident #013 prior to the RPN shift ending, both pre and post administration and pass the report to the oncoming RN and RPN. The MNP further indicated that both the oncoming and outgoing RPNs should have been performing the narcotics count together. The Manager for Nursing Practice further indicated once the error was found the reporting should have taken place immediately so that the incident did not go unreported to the Ministry of Health and Longterm Care (MOHLTC) until three business days later.

The licensee has failed to ensure that its Monitored Medications (Narcotics controlled and controlled like drugs) policy # INTERD-03-03-10, was complied with, specifically related to sections three and five, "Administration - monitored medications," sections one to five, "Shift change Narcotic Count" and sections two and three, "Care and Control of

Medication Cart Keys and Narcotic and Controlled Medication Keys." [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 iensuring that any policy, or system instituted or otherwise put in place was complied with, specifically related to resident #013 and medication management policy, to be implemented voluntarily.

WN #3: 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.

Related to Log #028736-17 involving resident #013:

A CIR was submitted to the Director for an incident that occurred on an identified date and time. The CIR indicated that a Narcotic and/or controlled substance count revealed that a scheduled dose of of an identified medication for resident #013 was unaccounted for.

A review of the Medication Administration Record (MAR) for resident #013 for an identified month, indicated that there was a physician order in place for an identified medication to be given by mouth once daily at an identified time.

During an interview, RPN #121 indicated he/she worked on the shift prior to the date the medication was unaccounted for, and earlier that shift resident #013 was agitated, at

which time the schedule dose medication was administered, as the resident did not have an order for as needed (PRN) dose of the medication. The RPN indicated forgetting to document on the Medication Administration Record as well as the resident's individual narcotic count sheet that the identified medication was given, as the RPN had gotten distracted.

During an interview, RPN #126 indicated that the date of the incident he/she had received the keys for the medication cart from RPN #121. RPN #126 indicated he/she did perform the narcotic count by him/herself and noticed that an identified medication for resident #013 was unaccounted for, and notified RN #128, who had contacted RPN #121 at home. RPN #126 indicated that he/she went ahead and gave resident #013 a second dose of the identified scheduled medication, as there was no documented evidence by RPN #121 indicating that resident #013 had received the same medication earlier that shift.

During an interview with the Manager of Nursing Practice indicated that the expectation related to the medication was that RPN #121 should have documented why it was important that resident #013 received a schedule dose of the identified medication prior to the shift ending, and a report of the medication administration should have been given to the oncoming RN and RPN.

RPN #121 did not ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber, as resident #013 received two doses of identified medication on an identified date, when the physician order indicated the resident was to receive one dose [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 ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber, specifically related to resident #013 receiving a dose of an identified medication that was not prescribed, to be implemented voluntarily.

WN #4: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, if any.

Related to Log #028736-17 involving resident #013:

A CIR was submitted to the Director for an incident that occurred on an identified date and time. The CIR indicated that an identified controlled substance count revealed that a scheduled dose of an identified medication for resident #013 was unaccounted for.

On an identified date, during interviews with RPN #121 and RPN #126 both indicated they administered to resident #013 a dose of an identified medication. The RPN #121 indicated that he/she did not document on the Medication Administration Record or the

residents individual narcotic count sheet that the identified medication was administered, as the RPN had gotten distracted. Both RPNs also indicated that they did not perform the narcotic count together.

Further review of the progress notes for resident #013 for a two month period as well as the Medication Incident Report on an identified date, failed to locate documented evidence to indicate immediate actions were taken to assess and maintain resident #013's health and whether the resident or the resident's Substitute Decision Maker (SDM) was notified of the medication incident. RPN #126 indicated that he/she went ahead and gave resident #013 a second dose of the identified scheduled medication, as there was no documented evidence by RPN #121 indicating that resident #013 had received the same medication earlier that shift.

During an interview with the Manager of Nursing Practice indicated there was no documentation to indicate that resident #013's SDM was notified of the above incident and indicated that expectation was that the nurse's document that the SDM was notified whenever there was a medication incident.

The Manager of Nursing Practice did not ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, if any, specifically related to resident #013 had an incident of a receiving an additional dose of an identified medication on an identified date. [s. 135. (1)]

2. The licensee has failed to ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed
(b) corrective action is taken as necessary, and
(c) a written record is kept of everything required under clauses

Related to Log #028736-17 involving resident #013:

A CIR was submitted to the Director for an incident that occurred on an identified date and time. The CIR indicated that a Narcotic and/or controlled substance count revealed that a scheduled dose of of an identified medication for resident #013 was unaccounted for.

A review of the investigation notes failed to locate documented evidence of corrective action taken to RPN #126 and #121 who were involved in the above identified medication

incident.

During an interview with the Manager of Nursing Practice indicated there was action taken by RPN #121, but no action was taken by RPN #126 related to the medication incident.

The Manager of Nursing Practice did not ensure that all medication incidents were documented, including corrective action that was taken as necessary, and a written record was kept of everything required under clauses, specifically related to RPN #126 performed a narcotic count by him/herself. RPN #121 administered a schedule dose on an identified medication prior to the shift ending and there was no documentation in resident #013's clinical health record to indicate the medication was administered, resulting in RPN #126 giving a second dose of the same medication to resident #013. Record review indicated there was no documented evidence to indicate what corrective actions were taken, as a result of the medication incident. [s. 135. (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 ensuring that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, if any. Ensuring that all medication incidents were documented, reviewed and analyzed and corrective action were taken as necessary, and a written record was kept of everything required under clauses, specifically related to a medication incident involving resident #013, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was notified no later than one business day after the occurrence of the incident of a missing or unaccounted for controlled substance.

Related to Log # 028736-17 involving resident #013:

A CIR was submitted to the Director for an incident that occurred on an identified date and time. The CIR indicated that an identified controlled substance count revealed that a scheduled dose of an identified medication for resident #013 was unaccounted for.

During an interview, the Manager of Nursing Practice (MNP) indicated he/she learned of the unaccounted for medication four days after the incident occurred. The MNP further indicated that the expectation was once the medication error was discovered the reporting should have taken place immediately, so that the incident did not go unreported for three business days later.

The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of the incident of an unaccounted for controlled substance, specifically related to an to an identified medication for resident #013 that was unaccounted for on an identified date and a report of the incident was not submitted to the Director until, three business days later. [s. 107. (3)]

Issued on this 12th day of February, 2018

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

Original report signed by the inspector.