Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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 soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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
Aug 29, 2019	2019_782736_0022	015450-19	Complaint

Licensee/Titulaire de permis

Grove Park Home for Senior Citizens
234 Cook Street BARRIE ON L4M 4H5

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

Grove Park Home For Senior Citizens
234 Cook Street BARRIE ON L4M 4H5

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

AMANDA BELANGER (736)

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): August 20-22, 2019.

The following intake was inspected during this Complaint inspection:
-One complaint submitted to the Director related to medication administration.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurse(s) (RNs), Registered Practical Nurse(s) (RPNs), Clinical Consultant Pharmacist, and family members.

During the course of the inspection, the Inspector conducted a daily tour of the resident care areas, observed the provision of care including medication administration, staff to resident interactions, reviewed health records, internal reports, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **4 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	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. 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):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that any missing or unaccounted for controlled substance was reported to the Director within one business day.

A complaint was submitted to the Director related to medication administration errors that had been made and reached resident #001. The complainant also indicated that the resident's physician and substitute decision maker (SDM) were not notified immediately of the second identified medication error.

Inspector #736 reviewed the medication incident reports in the home for the last quarter and noted that on three different dates within a one month period, resident #002's identified trans-dermal patch medication was internally reported to be missing.

a) The first medication incident report indicated that when staff went to change resident #002's identified trans-dermal patch medication, they were unable to locate the identified trans-dermal patch medication. The incident report further indicated that the staff checked and were unable to locate the identified trans-dermal patch medication. There was no indication on the medication incident form that the identified trans-dermal patch medication was ever located, and the Inspector was unable to locate any documentation in the resident's clinical records that indicated that the identified trans-dermal patch medication was located.

b) The second incident report indicated that when staff went to change resident #002's identified trans-dermal patch medication, they were unable to locate the identified trans-dermal patch medication. The incident report also indicated that an email would be sent to all staff to ensure that if the identified trans-dermal patch medication was not located on the resident, that registered staff were to be notified right away. There was no indication on the medication incident form that the identified trans-dermal patch medication was ever located, and the Inspector was unable to locate any documentation in the resident's clinical records that the identified trans-dermal patch medication was located.

c) The third medication incident report indicated that when staff went to change resident #002's identified trans-dermal patch medication, they were unable to locate the identified trans-dermal patch medication. A review of the progress notes for resident #002 by Inspector #736, indicated that the identified trans-dermal patch medication was noted to be missing at an identified time on the date, and was found approximately three hours later on the same day, in the resident's room on the floor. A review of a specified form also indicated that on that date, the identified trans-dermal patch medication for resident

#002 was found in a specified location, and put into the medication destruction bin.

The Inspector reviewed the reports submitted to the Director by the licensee, and was not able to locate any Critical Incident reports related to missing or unaccounted for controlled substances for the specified time period.

A review of the policy titled "Critical Incidents", NUR-03-20, last revised August 2017, indicated that a missing or unaccounted for controlled substance was to be reported to the Ministry of Health and Long Term Care (MOHLTC) within one business day, through the on-line Critical Incident System.

On August 31, 2018, the Director notified the licensees, via the Ministry of Health and Long Term Care Homes Portal of a memo, which clarified the reporting requirements of mandatory and critical incident reporting. The memo indicated that any missing or unaccounted for controlled substances, were to be reported to the Director within one business day.

In an interview with the Director of Care (DOC), they indicated to the Inspector that they were aware of the requirement to report missing or unaccounted for narcotics and controlled substances, however, they did not report the missing identified trans-dermal patch medication for resident #002, as the identified trans-dermal patch medication were found within a few hours. The Inspector requested that the DOC provide investigation notes for the missing identified trans-dermal patch medication, and was provided with an email dated after the second identified trans-dermal patch medication was reported missing, that indicated that two identified trans-dermal patch medication had not been located on resident #002 over a period of time, and to ensure that staff were aware during care to monitor for the identified trans-dermal patch medication. The DOC also provided the Drug Destruction and Disposal Monitored Substances sheet to the Inspector. Together, the DOC and Inspector reviewed the controlled substances that were signed in for destruction for the month in question, and only the third unaccounted for identified trans-dermal patch medication, was noted on the form. The DOC indicated that they felt that the identified trans-dermal patch medications were found within a few hours and therefore, not reported to the Director as missing; however, was unable to provide the Inspector with any evidence that the identified trans-dermal patch medication that were noted to be missing on the first two incidents, for resident #002, were located. [s. 107. (3) 3.]

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 all missing or unaccounted for controlled substances are reported to the Director within one business day, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that medications were kept in a medication cart that was secure and locked.

A complaint was submitted to the Director related to medication administration errors that had been made and reached resident #001.

During an observation on a specified home area on specific date during the inspection, Inspector #736 observed the Registered Practical Nurse (RPN) going in and out of a room, leaving the medication cart unlocked and unattended for approximately 10 minutes. During an observation on a different home area on the same date, the

Inspector observed the medication cart outside a room, unlocked and unattended for approximately two minutes with no registered staff within sight of the cart. On a different date during the inspection, the Inspector observed a medication cart on a third home area outside a room, unlocked and unattended for approximately three minutes, with no registered staff within sight of the cart.

In separate interviews with RPNs #102, #103 and #112, they indicated to Inspector #736 that any time they left the medication cart unattended, they were to ensure that it was locked for safety. Each RPN indicated to the Inspector that their respective medication cart on their home area was left unlocked and unattended at times during their medication pass. Each RPN further indicated that the medications were not kept safe and secured during the medication pass as a result of the cart being left unlocked and unattended.

In a review of the policy titled "The Medication Storage", from Medical Pharmacies number 3-4, last revised January 2018, indicated that all medication carts that were used to store required medications, were to be locked at all times when not attended by a nurse.

In an interview with the DOC, they indicated to the Inspector that all medication carts were to be kept locked at all times when the registered nurse left them unattended in any area of the home. The DOC further indicated that if the medication cart was observed to be unlocked and unattended, then the medication was not kept secure. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances were stored in a separate, double locked area within the locked medication cart.

During observation of a medication pass on a specified date during the inspection, on a specific home area, Inspector #736 observed RPN #103 enter a drawer of the medication cart and remove medication from a storage bin without the use of a key.

In an interview with RPN #103, they indicated to the Inspector that controlled substances were kept in a drawer of the medication cart in a bin, and that the bin required a key to access it. The RPN further indicated that during medication administration, the bin that the controlled substances were stored in, was not always kept locked, and at times, the medication cart and the controlled substance bin were both unlocked and unattended. The RPN indicated to the Inspector that the controlled substances were not always kept stored in an area that was double locked within the medication cart, as both the bin and

medication cart were unlocked and unattended.

During further observations of medication carts with RPN #102 and #110 on a different date during the inspection, the Inspector observed the area where controlled substances were stored, within the medication cart on two other home areas, and noted the bins to not be locked within the medication cart.

In separate interviews with RPNs #102 and #110, they indicated that controlled substances were kept in a separate area of the medication cart that was to be kept locked at all times. Both RPNs indicated that when the Inspector observed the medication carts, the area where the controlled substances were stored was unlocked, and therefore the controlled substances were not kept double locked.

In a review of the policy titled "The Medication Storage" number 3-4, last revised January 2018, indicated that all narcotics and controlled medications were to be kept locked and separated from other regular medications in the cart. The policy further indicated that in Ontario, narcotics and controlled medications were to be double locked in the cart or cabinet in a locked room.

In an interview with the DOC, they indicated to the Inspector that the narcotics and controlled substances were kept in the medication cart in a separate bin that was to be kept locked, within the locked medication cart. The DOC further indicated to the Inspector that if the medication cart and the narcotic bin were not locked and left unattended, then the narcotics and controlled substances were not kept in a double locked area within the medication cart, and should have been. [s. 129. (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 medications are kept secure and locked, and controlled substances are kept double locked, 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.

A complaint was made to the Director related to two medication errors that took place for resident #001. The complainant further explained that there was a medication error on a specified date, related to medication intervention A being given twice in one day; and, an additional medication error on a separate date, related to medication intervention B. The complainant indicated to the Inspector that they felt that the resident's SDM was not notified at the time of the incident of the second error, nor was the resident's physician.

a) Inspector #736 reviewed resident #001's clinical records and noted a physician's order, that provided direction to staff to administer medication intervention A once a day, on specific days of the week.

The Inspector reviewed the resident's electronic medication administration records (eMAR) and noted that medication intervention A was scheduled to be administrated on specific days of the week, as per the physician's order, to be given at a specified time. The Inspector reviewed the eMAR for resident #001, and noted that medication intervention A had been signed off as given by RPN #102 at a specific time.

The Inspector reviewed resident #001's progress notes for the specified date, and identified an entry that indicated that RPN #103 became aware that the resident had received medication intervention A at their physician's prescribed time of the specified date, as well as an additional dose at a later time on the same date. The entry further indicated that the RPN re-checked the eMAR and identified that medication intervention A was not scheduled to be given at the second administered time, and the SDM was notified of the medication error a short time later.

In an interview with Inspector #736, RPN #103 indicated that they had worked the shift on the specified date, and checked the eMAR related to resident #001, and thought that

they had seen direction to provide medication intervention A during their shift. The RPN provided medication intervention A to resident #001, and then determined that it was a medication error. The RPN indicated that at the time, the medication had not been given as per the prescriber's direction, however, after the medication was administered, the Physician was contacted and provided an order for the additional dose that had already been given.

In an interview with the DOC, they indicated to the Inspector that registered staff would review the resident's eMAR screen on Point Click Care (PCC) and verify what medications were to be given to each resident at which time. The DOC further indicated that they were aware that resident #001 had received an additional dose of medication intervention A on the specified date. The DOC indicated that the medication was not given as per the prescriber's direction.

b) Inspector #736 reviewed resident #001's health records and noted a physician's order from the Nurse Practitioner (NP) dated a second specified date, that instructed staff to perform a specified task at specified intervals during the day, and, provide medication intervention B, based on the outcome of the specified task.

The Inspector reviewed the home's internal medication error report, which was filled out on a specified date, by RPN #105, which indicated that during the specified medication pass, the resident was to receive medication intervention B. The report further documented that based on the results of a specified task, the resident should have received a specified amount of medication intervention B, however, received over double the amount of medication intervention B, as the RPN "got confused".

The Inspector reviewed resident #001's progress notes, and identified an entry a day after the medication incident, that indicated that Registered Nurse (RN) #101 was made aware during shift report that a medication error took place the shift prior. The progress note indicated that the resident received a specified amount of medication intervention B, instead of the required amount.

In an interview with Inspector #736, RPN #105 indicated that they had performed a specified task for resident #001, and then when compared it to directions for medication intervention B, they became confused, and administered the wrong amount of medication intervention B to the resident. The RPN indicated that they became aware of the error towards the end of their shift, when they double checked their eMAR records, and identified that the wrong amount of medication intervention B was administered.

In an interview with the DOC, they indicated to the Inspector that they were aware of the medication incident that took place related to resident #001 on the specified date involving medication intervention B. The DOC indicated that the RPN had misread the instructions, and administered a larger than ordered amount of medication intervention B. The DOC further indicated that the medication administered to resident #001 on the specified date, was not administered as per the prescriber's directions. [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 medications are administered to residents in accordance with the directions for use specified by the prescriber, 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 for every medication incident involving a resident, the resident's SDM, and attending physician were notified.

A complaint was made to the Director related to resident #001 and a medication error involving medication intervention B on a specified date. The complainant indicated that it was their understanding that the resident's doctor was not notified of the error, and that the resident's SDM was not notified until the next day of the error. Please see Written Notice (WN) #3 for further details.

Inspector #736 identified a progress note at a specified time on a specified date, by RN #101, which indicated that they had been made aware at shift report that there was a medication error identified during the shift prior. Specifically, that the RPN had administered a larger than prescribed amount of medication intervention B. The progress note further indicated that RN #101 informed the SDM of resident #001's medication error at that time. An additional progress note on same date (one day after the medication incident), approximately one hour later, indicated that the physician on

call was notified of the medication error.

In an interview with RN #104, they indicated to the Inspector that they were made aware of the medication error, involving resident #001 near the end of the shift, however, they were unsure of exactly what time. The RN further explained to the Inspector that they did not feel it was necessary to contact the on call physician at that time, as the on call physicians were unfamiliar with the resident, and would have "just indicated to [perform a specified task] to monitor resident #001", which they were already doing. The RN further explained that they did not contact the resident's SDM at that time, due to the time of day, and the resident remained stable. The RN did indicate that if the resident became unstable, the SDM and physician would have been notified.

A review of the policy titled "Medication Incidents" NUR-03-19, last revised August 2017, indicated that the resident's most responsible physician or physician on call would be notified for monitoring orders, treatment orders and/or direction.

A review of the policy titled "Medication Incident Reporting", 9-1, from Medical Pharmacies, last revised January 2019, indicated that the resident's substitute decision maker and the resident's attending physician were to be notified of every medication incident that involved a resident.

In an interview with the DOC, they indicated to the Inspector, that each time there was a medication error, registered staff were to fill out an online form that notified both the pharmacy and themselves of the error. The DOC further indicated that the nurse was responsible to notify the resident's SDM and physician related to a medication incident. The DOC explained that it was their understanding that the RN who was made aware of the medication error in relation to resident #001, informed the Physician or Nurse Practitioner, and the resident's SDM of the error. Together, the DOC and the Inspector reviewed the progress notes related to the medication error for resident #001. The DOC indicated, that based on the progress notes, the medication error was noted at a specific time of a specified date, and the SDM of resident #001 was not notified until the next day. The DOC further indicated, that based on the progress notes, it appeared that a physician was first made aware of the error the next day. The DOC indicated that both the SDM and physician should have been made aware of the medication error involving resident #001 when the medication error was discovered. [s. 135. (1)]

2. The licensee has failed to ensure that a written record was kept for the review and analysis, as well as the corrective actions taken as necessary for all medication incidents.

A complaint was submitted to the Director related to medications errors that reached resident #001. Please see WN #3 and #4, finding one, for additional information.

A review of the policy titled "Medication Incident Reporting", number 9-1, last revised January 2019, indicated that for an incident that originated from nursing or the prescriber, the Director of Nursing/Nurse Manager would initiate corrective action. The policy further indicated that there was to be continued documentation of analysis, monitoring, and communications related to the incident until the final report was submitted.

a) Inspector #736 reviewed resident #001's progress notes, and noted that on specified date, the resident was given an additional dose of medication intervention A.

The Inspector then reviewed the home's internal medication incident form, which indicated that it was the final report. The medication incident form indicated that resident #001 received an additional amount of medication intervention A in the same day, and that the resident was monitored, and, the doctor and SDM, as well as the DOC were notified of the error. The medication incident form also indicated that the doctor provided an order for the additional dose of medication intervention A after it had been given to the resident. The form did not have any indication of the review and analysis, or the corrective actions taken.

In an interview with RPN #103, they indicated that they had informed the RN on shift immediately when they identified the medication error, but could not recall if there was any further follow up related to the medication error.

In an interview with the DOC, they indicated to the Inspector that they reviewed each medication error, and followed up with the individual staff, however, they did not keep a record of the individual one on one conversations that took place after a medication error had been identified.

b) Inspector #736 reviewed resident #001's progress notes, and noted that on a specified date, the resident was given a specified amount of medication intervention B, when, based on a specified task that was performed on the resident, they should have received a lesser amount of medication intervention B.

The Inspector then reviewed the home's internal medication incident form, related to resident #001 and medication intervention B, which indicated that it was the final report.

The medication incident form indicated that resident #001 received a specified amount of medication intervention B, when they should have not. The medication incident form also indicated that the resident was monitored with a specified intervention. The form did not have any indication of the review and analysis, or the corrective actions taken.

In separate interviews with RPN #105 and RN #104, they indicated to the Inspector that there was not ever any follow up with the staff related to any medication errors that were submitted to the DOC.

In an interview with the DOC, they indicated that after the medication error was identified, they followed up with the Nurse Practitioner (NP) regarding the directions for medication intervention B that was written, as well as followed up with the RPN who administered the wrong dose of medication intervention B. The DOC further indicated that there was no written record kept of the corrective actions taken related to the medication error, however, they did have the NP re-write the directions for intervention B. [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 to ensure that the physician and SDM are notified of medication errors, to be implemented voluntarily.

Issued on this 4th day of September, 2019

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

Original report signed by the inspector.