Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 27, 2016	2016_449619_0028	018731-16	Complaint

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

Hawthorn Woods Care Community
9257 Goreway Drive BRAMPTON ON L6P 0N5

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

SAMANTHA DIPIERO (619)

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): September 7, 8, 9, 2016.

The following complaint inspection was completed: #018731-16 related to skin and wound and medication administration.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), and family members. The inspector also toured the facility, observed the provision of care, and reviewed the home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication
Skin and Wound Care

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

2 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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 :

The licensee failed to ensure that the plan, protocol, procedure, strategy or system was complied with.

A) Resident #001 required an identified medication three times daily before meals. On an identified date in August 2016, a medication re-order request was faxed to the home's pharmaceutical provider. A review of the resident's drug re-order fax submission confirmed that the medication was ordered but not received by the home. The resident did not receive their scheduled medication on two identified dates in August 2016, and missed a total of five doses. Interview with RPN #106 confirmed that they were aware the medication was missing and that no attempt to follow up with the pharmaceutical provider was made on two identified dates in August 2016. Interview with RPN #104 indicated that the medication incident was identified three days after the medication stock was depleted and confirmed that no Medication Incident Report was completed for the missed administration of the identified medication until four days after the error was identified. The home's policy titled "Medication Incidents", policy #04-09-10, last reviewed June 2014, stated that "All medication incidents, including near misses or close calls that are identified are reported immediately to the nurse or designate and to the Director of Nursing Care… A Medication Incident Report must be completed promptly and sent to the Director of Nursing Care". An interview with the Assistant Director of Care (ADOC), confirmed that the registered staff failed to submit a medication incident report for the missed medication administration to resident #001.

B. Resident #001 obtained an injury during the provision of morning care on an identified date in July 2016. Resident's #001's private care provider arrived at the home and discovered the resident was injured and inquired with a PSW staff about the resident's injury but was not given a clear answer of how or when the injury occurred. Interview with family members indicated that the private care provider was informed by the PSW that the RPN was aware of the resident's injury. After being informed of the injury by the private care provider, the resident's Substitute Decision Maker (SDM) arrived on site, and was not given a clear explanation of the origin or treatment of the injury by staff. Interview with RPN #104 indicated that they were made aware of the resident's injury prior to the arrival of the resident's private care provider to the home, and were not aware that the private care provider had informed the SDM of the resident's injury. RPN #104 did not inform the SDM of the resident's injury for a period of two to four hours because they were expecting the resident's SDM to attend the home and did not call to inform the

family member of the injury. A review of the home's policy titled "Internal Incident Reporting", policy #XXIII-C-10.70, last revised July 2016, stated that "the charge person will notify next of kin, family, or substitute decision maker". Interview with RPN #104 stated that registered staff were expected to inform the SDM of any significant changes in the resident's condition as soon as possible and confirmed that this was not done.

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 with r. 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 is complied with, 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 :

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) Resident #001 required an identified medication once daily for seven days to treat an identified medical issue. This medication was ordered on an identified date in August 2016, and the physician's medication order instructed that the medication be re-assessed after seven days. Review of the Medication Administration Record (MAR) indicated that the resident received an extra seven doses over the course of the following seven days after the medication was to be re-assessed, in August 2016, and was transferred to hospital on an identified date in August 2016, for treatment of identified symptoms,

fourteen days after the medication was prescribed. A review of the medication error incident report indicated that the home's pharmaceutical supplier incorrectly entered the duration of this medication as "Indefinite" and delivered excess medication to the home for resident #001. RPN #104 stated that the MAR will indicate that a medication is not to be given i.e. discontinued or held for re-assessment, by making an "X" in the box area where staff sign for a medication, but that due to the pharmacy transcription error the box spaces were empty. RN #105 confirmed that staff did not re-check the written order and confirmed that the medication was continued for a period of seven days past the physician's ordered re-assessment date. Interview with RPN #104 stated that when medication orders required re-assessment, registered staff were to flag the resident's chart for review by the home's physician and to not administer that medication to the resident until otherwise instructed to by the prescribing physician. Interview with the ADOC confirmed that the registered staff continued to provide the medication to resident #001 and did not administer the prescribed medication in accordance with the directions for use specified by the prescriber.

B) Resident #001 required an identified medication three times daily before for management of a chronic condition. The resident's medication was re-ordered by RPN #104 on an identified date in August 2016. The ADOC confirmed that the medication order was faxed correctly and that the pharmaceutical provider failed to send the medication as requested on the re-order form. A review of the MAR indicated that the resident failed to receive the medication on two identified dates in August 2016, and in total, missed five doses of the medication. Interview with the ADOC confirmed that resident #001 missed a total of five doses of medication and confirmed that registered staff did not administer the prescribed medication in accordance with the directions for use specified by the prescriber.

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 with r. 131. (2) where the licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 28th day of September, 2016

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

Original report signed by the inspector.