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
Dec 1, 2020	2020_781729_0025	016959-20	Critical Incident System

Licensee/Titulaire de permis

2063412 Ontario Limited as General Partner of 2063412 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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

Creedan Valley Care Community
143 Mary Street Creemore ON L0M 1G0

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

KIM BYBERG (729)

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): November 17 - 20, 2020.

The following intakes were completed within the critical incident inspection:

Log #016959-20 related to a medication incident

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Primacare Living Solutions Consultant, Director of Quality and Infection Control Primacare, Rai-Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Environmental Manager, Dietary Supervisor, housekeeper, and Residents.

During this inspection, inspector(s) toured and observed resident care areas; and common areas, observed residents and the care provided to them, reviewed relevant clinical records, policies and procedures, schedules, education records; and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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 failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, corrective actions taken, and a written record kept.

A) A resident's medication patch could not be located on their body. A physician’s order was obtained to apply a patch. Later in the day, a head to toe assessment revealed two patches were located on the resident.

A medication incident report was completed; however, the home's investigation was not documented, there was no action plan developed, nor was there a written record of the education that was identified by the home as being completed as a result of the incident.

B) Two residents had medication incident reports completed by the home for medications that were not given as prescribed. The home did not complete a review of the incidents, analyze, or take any corrective actions as a result of the medication incidents.

The Home's policy titled "Medication Incident Reporting" policy 9-1 last revised June 2020 stated that time should be assigned to review incident details, immediate actions and correction plans, to keep a record of the online report, analysis and a review of the incident with the Director of Care. The pharmacy consultant would report the consolidated reviews of the incidents with the medication safety team in the home and discuss system/process improvements to avoid future incidents.

The home did not investigate, review, analyze, or take action for all of the medication incidents which put residents at risk for further medication incidents and the risk of continued knowledge deficit for staff related to their medication administration practices.

Sources: Interviews with, ADOC #104, Primacare Consultant, review of the residents eMAR and clinical record, medication audit report, Medication Incident Reporting Policy #9-1 last revised June 2020, and Medication incident reports. [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 all medication incidents and adverse drug reactions are documented, reviewed and analyzed, corrective action is taken as necessary, and a written record is kept., 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 failed to ensure that medications were administered to residents in accordance with the directions for use by the prescriber.

The following is further evidence to support the order issued on June 8, 2020, during inspection 2020_781729_0005 with a compliance date of November 20, 2020.

A resident was assessed by two registered staff members and the Registered Practical Nurse (RPN) found that the resident did not have on their prescribed patch.

In response to the missing patch, the physician ordered a new patch to be applied. Later in the evening the residents' condition changed and an assessment of the resident revealed the missing patch along with the newly applied patch.

The application of a second patch put the resident at risk of serious medical harm.

Sources: Interviews with RPN, RN, PSW, DOC, ADOC, review of the residents eMAR and clinical record including pain assessments, medication audit report, Medication Incident Reporting Policy #9-1 last revised June 2020, and Medication incident report. [s. 131. (2)]

Issued on this 7th day of December, 2020

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

Original report signed by the inspector.