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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 24, 2013	2013_109153_0012	T-2188-12	Complaint

Licensee/Titulaire de permis

2063412 ONTARIO LIMITED AS GENERAL PARTNER OF 2063412 INVESTMENT LP
302 Town Centre Blvd., Suite #200, MARKHAM, ON, L3R-0E8

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

LEISUREWORLD CAREGIVING CENTRE - MUSKOKA
200 KELLY DRIVE, GRAVENHURST, ON, P1P-1P3

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

LYNN PARSONS (153)

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): May 13, 14, 15, 23, 2013

During the course of the inspection, the inspector(s) spoke with Acting Director of Care(DOC), Assistant Director of Care(ADOC), Pharmacist, Registered Practical Nurses(RPN)and Family.

During the course of the inspection, the inspector(s) Reviewed clinical health records, physician agreements, narcotic counts, medication incident reports and home policies related to orientation and medication administration. Completed observation of a medication administration pass.

The following Inspection Protocols were used during this inspection: Medication

Findings of Non-Compliance were found during this inspection.

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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 :

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1. The licensee did not ensure that no drug is administered to a resident in the home unless the drug has been prescribed for the resident.
A medication that had not been prescribed was administered to Resident #1.
The resident experienced a significant change in health status which required transfer to hospital for assessment.
It was identified by hospital staff that the reason for the decline in the resident's condition was due to the medication that had not been prescribed for the resident. [s. 131. (1)]

2. The licensee did not ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.
Resident #2 was prescribed a medication that was to be administered every 72 hours.
According to the medication administration record for Resident #2 the medication was to be administered on October 14th and 27th, 2012.
A review of the medication administration record for October 2012 revealed the medication was administered on October 15th and 28th and not as prescribed.
When interviewed the Acting Director of Care confirmed the medication had not been administered in accordance with the directions 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 to ensure that;
- no drug is administered to a resident in the home unless the drug has been prescribed for the resident
- drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #2: 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).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

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1. The licensee did not ensure all medication incidents are documented, reviewed and analyzed.
Resident #2 was prescribed a medication that was to be administered every 72 hours. A review of the medication administration records for October 2012 revealed the resident did not have the medication administered on October 27th, 2012 as ordered by the physician. The medication was administered a day later on October 28th, 2012.
A review of the medication incident reports failed to locate an incident report for the missed dose.
When interviewed the Acting Director of Care confirmed a medication incident report had not been completed for the missed dose. [s. 135. (2)]

2. The licensee did not ensure that a written record is kept of a quarterly review of all medication incidents that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents.
Through interviews conducted in the home it was identified that a review of the medication incidents is completed at the Professional Advisory Committee meetings scheduled on a quarterly basis.
A review of the minutes of the Professional Advisory meeting held on January 28, 2013 failed to reveal a written record of the medication incidents that had occurred in the previous quarter.
When interviewed the Acting Director of Care confirmed a written record of the quarterly review was not available. [s. 135. (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 medication incidents are documented, reviewed and analyzed
- a written record is kept of a quarterly review of all medication incidents that have occurred in the home since the time of the last review, to be implemented voluntarily.

WN #3: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee did not ensure the provision of care set out in the plan of care is documented.
A review of the medication administration record for Resident #3 revealed medications administered on May 8 and 12, 2013 at 08:00h were not documented as given.
An interview with the RPN who completed the medication pass on the noted dates confirmed the prescribed medication was administered to Resident #3 but was not documented on the medication administration record. [s. 6. (9) 1.]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 12. Every licensee of a long-term care home shall ensure that there is an organized program of medical services for the home. 2007, c. 8, s. 12.

Findings/Faits saillants :

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1. The licensee did not ensure that there is an organized program of medical services for residents admitted as short stay.
On November 19, 2012, Resident #1 who was admitted to the short stay program, exhibited a significant change in condition involving respiratory distress.
The POA for Personal Care requested the resident be assessed by the long term care home physician who was on site at that time.
The registered staff informed the POA that the long term care home physicians do not provide medical services to short stay residents rather medical services are provided by the short stay resident's family physician.
The resident's family physician was not notified on November 19, 2012.
On November 20, 2012, Resident #1's health status deteriorated further and the POA requested that the resident's family physician be notified and provided the contact information. Although the family physician was contacted and provided verbal orders, the resident's condition deteriorated further.
On November 21, 2012 the resident was transferred to hospital and diagnosed with an accidental overdose from a medication that had been administered in error on November 18, 2012.
A review of the Medical Director's Agreement did not provide clarity as to who was responsible for short stay residents' medical coverage.
Registered staff confirmed when interviewed that residents in the short stay program are provided medical services by their family physician and not by the long term care home physicians. In contrast when the Acting Director of Care was interviewed, she confirmed that the on call physician can be contacted for short stay residents who experience a significant change in condition. [s. 12.]

Issued on this 18th day of June, 2013

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