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

Division de la responsabilisation et de la performance du système de santé
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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
Oct 22, 2015	2015_297558_0015	T-1695-15	Resident Quality Inspection

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

Muskoka Shores Care Community
200 KELLY DRIVE GRAVENHURST ON P1P 1P3

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

BARBARA PARISOTTO (558), DIANE BROWN (110), JOELLE TAILLEFER (211), VALERIE PIMENTEL (557)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 20, 21, 24, 25, 26, 28, 31, September 1, 2, 3, 4, 2015.

During the course of the inspection critical incidents T-2737-15, T-1941-15, T-1433-14 and T-338-13 were completed.
During the course of the inspection complaint T-2216-15 was completed.

During the course of the inspection, the inspector(s) spoke with the executive director (ED), directors of care (DOC), assistant director of care (ADOC), director of resident programs (DRP), director of food services (DFS), director of environmental services (DES), resident relations coordinator (RRC), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), family members and residents.

During the course of the inspection, the inspectors conducted a tour of the home, conducted a dining observation, medication administration observation, observed resident and staff interactions, reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

11 WN(s)
7 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 :

1. The licensee has failed to ensure that 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.

a.) The home's policy in the MediSystem Pharmacy, subject Change of Direction, Index #04-02-30, revision date of June 23, 2014, indicated that a change of direction label must be affixed to any medication that has had a change of direction as ordered by the physician.
During the review of a drug storage area for narcotics and controlled substances located on an identified home area the inspector observed a box containing four ampoules of an identified medication for resident #006. The resident's original label identified instructions to administer a specified dose of the medication at a specified time. An unidentified nurse hand wrote changes in directions on the box containing the medication. The box did not have a change of direction label affixed to it.

An interview with RPN #103 and DOC #113 confirmed that someone had hand written the change in direction onto the resident's identified medication box and did not affix a change in direction label. The home did not follow the policy of affixing a new label indicating a change of direction.

b.) The home's policy in the MediSystem Pharmacy, subject Narcotic and Controlled Substances, Index #04-07-10, revision date of June 23, 2014, indicated that the nurse

must transfer all the information received in regards to narcotics or controlled substances onto subsequent pages of the narcotic and controlled substance administration record. The inspector reviewed the narcotic and controlled substance administration record for resident #013 and the dosage of an identified medication was not indicated on the record. Resident #012's directions for an identified medication was omitted and the direction to administer a second identified medication was incorrect on the narcotic and controlled substance administration record.

An interview with RPN #105 and DOC #113 confirmed the home's policy to transfer all information onto subsequent pages was not followed.

This same policy also identifies that a daily count of all narcotic and controlled substances must be done by two nurses at the time of every shift change.

A record review of resident #015's plan of care revealed on an identified date, the resident received an identified medication at 11:30 a.m. and 4:50 p.m. At the shift change count at 10:00 p.m. between RPN #120 and RPN #125 it was identified that one tablet of the identified medication was missing. An interview with RPN #120 confirmed one tablet of this medication was missing.

Review of the home's investigative notes and an interview with DOC #113 confirmed that RPN #125 and RPN #126 did not do a shift count together of the narcotics and controlled substances at the change of shift. [s. 8. (1) (b)]

2. The home's policy Restraint Implementation Protocols VII-E-10.00 revised January 2015 states in the procedure:
- when a resident or positioning device is identified as a need for the resident, consider alternatives to restraint use and document alternatives trialed on Restraint/PASD Alternative Checklist Assessment.
An interview with the ADOC revealed the home's expectation is a quarterly assessment is conducted for each resident who is using a restraint and the policy was revised during the inspection to include:
- conduct quarterly assessment of each resident who is restrained using the Restraints/PASD Alternative Checklist Assessment.
Through observation, record review and staff interviews, it was confirmed that resident #001 uses bed rails and a tilt chair as restraints. A review of the plan of care did not locate a Restraint/PASD Alternative Checklist Assessment for the use of these restraint devices.

An interview with the ADOC revealed the home's expectation is that the Restraint Alternative Checklist Assessment be completed at the initiation of a restraint and on a quarterly basis thereafter. The ADOC confirmed that initial and quarterly assessments were not completed when the bed rails or tilt chair restraints were implemented for resident #001. [s. 8. (1) (b)]

3. The home's policy Restraint Implementation Protocols VII-E-10.00 revised January 2015 states in the procedure:
- when a resident or positioning device is identified as a need for the resident, consider alternatives to restraint use and document alternatives trialed on Restraint/PASD Alternative Checklist Assessment.
An interview with the ADOC revealed the home's expectation is a quarterly assessment is conducted for each resident who is using a restraint and the policy was revised during the inspection to include:
- conduct quarterly assessment of each resident who is restrained using the Restraints/PASD Alternative Checklist Assessment.

Through observation, record review and staff interviews, it was confirmed that resident #002 used bed rails as restraints since 2013. A review of the plan of care did not locate a Restraint/PASD Alternative Checklist Assessment for the use of bed rail restraints. An interview with the ADOC revealed that the home's expectation is that the Restraint/PASD Alternative Checklist Assessment be completed at the initiation of a restraint and on a quarterly basis thereafter.

The ADOC confirmed that quarterly assessments were not completed when the bed rail restraints were implemented in 2013 for resident #002. [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 to ensure that 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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, other safety issues related to the use of bed rails are addressed, including height and latch reliability.

a.) Record review and observations confirmed that resident #002 required two bed rails in bed. The resident confirmed that he/she was unable to get out of bed when then rails were raised. Staff interviews and records confirmed the use of bed rails as a restraint for this resident.
A review of the home's bed system evaluation is completed by way of an audit. The audit was reviewed and included an audit of resident #002's bed. The audit did not include the height of resident #002's bed rails. [s. 15. (1) (c)]

2. b.) Record review, observations and staff interviews confirmed that resident #001 required two half bed rails in bed and confirmed the bed rails are considered a restraint. A review of the home's bed system evaluation revealed an audit of beds equipped with bed rails. The audit did not include the height of resident #001's bed rails.

An interview with the DES, who oversees the auditing process, confirmed that the height of bed rails was not measured and that he/she was unaware of the bed rails' height. An interview with the ADOC, the home's lead for restraints, was not involved in the home's bed system evaluation and was unaware of the height of the bed rails. [s. 15. (1) (c)]

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 where bed rails are used, other safety issues related to the use of bed rails are addressed, including height and latch reliability, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident’s plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident’s plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care includes an order by the physician or the registered nurse in the extended class.

On a specified date in August, resident #001 was observed at 10:04 a.m. lying in bed with two half bed rails in the upright position. On the same date, the resident was observed at 2:23 p.m. sitting in a tilt chair in a tilt position.
A review of the resident’s plan of care identified the bed rails as a restraint. A review of the physician’s orders did not include an order for the bed rails and the tilt chair.

An interview with staff #106 and the ADOC confirmed the use of bed rails and the tilt chair for resident #001 are considered restraints and require a physician’s order for their use. [s. 31. (2) 4.]

2. The licensee has failed to ensure that the restraint plan of care includes the consent by the resident or if the resident is incapable, by the SDM.

a.) Resident #002's plan of care and staff interviews identified the use of two side rails as a physical restraint when the resident is in bed. The resident's plan of care revealed that side rails for this resident have been used since 2013. Resident interview revealed that he/she could not get out of bed when the side rails are up/in place. Record review identified a physician's order and regular monitoring of this restraint, however no consent. The home's policy # VII-E-10.00 Restraint implementation protocols dated January 2015, directs the registered nurse/registered practical nurse to obtain a written consent for the initial restraint use, annually there after and upon any change in the restraint order. [s. 31. (2) 5.]

3. b.) On a specified date in August, resident #001 was observed at 10:04 a.m. lying in bed with two half bed rails in the upright position. On the same date, the resident was observed at 2:23 p.m. sitting in a tilt chair in a tilt position.
A review of the resident’s plan of care identified the bed rails as a restraint. Interviews with staff #101 and #106 confirmed the tilt chair was a restraint. A chart review did not locate a consent form for the bed rails and tilt chair.

An interview with RPN #106 and the ADOC confirmed the use of bed rails and the tilt chair are restraints and that written consent for the use of these restraints were not in place. [s. 31. (2) 5.]

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 restraint plan of care includes an order by the physician or the registered nurse in the extended class, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every year, a survey will be taken of the residents and their families to measure their satisfaction with the home and care, services, programs and goods provided at the home.

A review of the home's process for measuring resident and family satisfaction in 2014 involved the use of the stage 1 questions from abaqis and two additional questions pertaining to overall satisfaction and recommendation of the facility.

An interview with the ED confirmed the survey questions did not measure satisfaction of services such as physiotherapy, occupational therapy, foot care and hair dressing. This finding was issued previously as a written notification during the home's Resident Quality Inspection (RQI) in September 2014. [s. 85. (1)]

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 at least once in every year, a survey will be taken of the residents and their families to measure their satisfaction with the home and care, services, programs and goods provided at the home, to be implemented voluntarily.

WN #5: 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 drugs are stored in an area or a medication cart that is secure and locked.

In August 2015, the inspector observed on an identified home area, the medication cart unlocked and no registered staff present. Several minutes later RPN #105 came out of a resident's room. When the inspector asked why the cart was left unlocked the RPN said I should have locked it but I didn't.

RPN #105 and DOC #113 confirmed the medication cart must be locked at all times when the registered staff are not present. [s. 129. (1) (a)]

2. The licensee has failed to ensure that 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.

The home's medication carts contain a double lock system to ensure controlled substances are double locked. There is a lock on the medication cart and a lock on the controlled substance drawer inside the medication cart.

In August 2015, the inspector observed the medication cart located on an identified home area unlocked and with no registered staff present.

RPN #105 and DOC #113 confirmed the medication cart must be double locked at all times when not in use or staff present to ensure the control substances remain double locked. [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 drugs are stored in an area or a medication cart that is secure and locked
- to ensure that 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, to be implemented voluntarily.

WN #6: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

On an identified date and time resident #014 was administered eight of his/her medications by RPN #136. Approximately an hour later RPN #136 administered resident #015’s medication to resident #014.

An interview with RN #116 confirmed he/she was called to assess resident #014 when RPN #136 realized that he/she had administered resident #015’s medication to resident #014. Upon assessment of the resident's condition a decision between the RN and the ADOC was to send the resident to hospital for an assessment, the resident was assessed at the hospital, monitored and returned to the home the same day.

Upon review of the home's investigative notes and an interview with DOC #113, RPN #136 had pre-poured resident #015’s medication and left the medication unlabeled sitting on top of the medication cart. RPN #136 had no explanation as to why he/she had administered resident #015’s medication to resident #014. He/she had realized what he/she had done and called RN #116 when resident #015 asked for his/her medication.

RN #116 and DOC #113 confirmed the home failed to ensure resident #014 received only his/her medication as prescribed for him/her. [s. 131. (1)]

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 used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene; O. Reg. 79/10, s. 219 (4).
(b) modes of infection transmission; O. Reg. 79/10, s. 219 (4).
(c) cleaning and disinfection practices; and O. Reg. 79/10, s. 219 (4).
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes hand hygiene.

A review of the home's infection control statistics revealed there had been five outbreaks between December 2014 and March 2015. There were three respiratory and two enteric. A complaint received by the Ministry indicated ill staff were working and not practicing proper infection control practices when washing their hands or applying personal protective equipment (PPE).

Record review of the home's Hand Hygiene educational records revealed 11 per cent of staff did not receive hand hygiene education through the PPE education in 2014. Eight per cent of staff did not receive hand hygiene education through the infection control fundamentals education in 2014.

An interview with the ADOC who is also the infection prevention and control lead confirmed that all staff did not receive annual training or retraining in hand hygiene. [s. 219. (4) (a)]

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 training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes hand hygiene, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure when a person who had reasonable grounds to suspect any abuse of a resident by anyone that resulted in harm or risk of harm has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.

Review of a critical incident report indicated an identified resident struck another identified resident.
Review of the progress notes and interview with PSW #134 indicated resident #050 struck co-resident #051 four times without provocation. The co-resident sustained an injury.

Interview with DOC #112 confirmed the incident was not reported immediately to the Director and was reported the following day. [s. 24. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the analysis undertaken of every incident of abuse or neglect of a resident at the home are considered in the evaluation.

Review of the home annual evaluation titled “Annual Evaluation Template” dated February 18, 2015, does not indicate that the results of the analysis of every incident of abuse or neglect of a resident at the home was considered in the evaluation for the past year.

Interview with DOC #112 and the ED confirmed that the home's annual evaluation dated February 18, 2015, did not indicate that the results of the analysis of every incident of abuse or neglect of a resident at the home were considered in the evaluation for the past year. [s. 99. (c)]

WN #10: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident is reported to the pharmacy service provider.

On an identified date, a medication incident occurred that involved resident #014 receiving resident #015’s medication. RPN #136 completed a medication incident report, however, the pharmacy was not notified.

The home’s process when a medication error occurs is a medication incident report is completed and faxed to the pharmacy to inform them that an incident had occurred.

Record review of the pharmacy incident report revealed the home did not fax the incident report to the pharmacy.

DOC #113 confirmed the pharmacy service provider was not notified of the medication incident involving resident #014 receiving another resident's medication. [s. 135. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that on every shift symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Resident #008 developed a medical condition on an identified date. Record review revealed the resident was started on daily medication and placed in isolation. Record review revealed there was no record of monitoring symptoms for 8 shifts during the identified period of time.

An interview with RPN #129 and the ADOC confirmed that the resident was not monitored for symptoms every shift. The ADOC confirmed the home's expectation is residents are to be monitored every shift. [s. 229. (5) (a)]

Issued on this 27th day of October, 2015

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

Original report signed by the inspector.