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 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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 26, 2018	2018_674610_0021	006559-17, 008932-18, 010250-18, 027969-18	Critical Incident System

Licensee/Titulaire de permis

Steeves & Rozema Enterprises Limited
265 North Front Street Suite 200 SARNIA ON N7T 7X1

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

Westmount Gardens Long Term Care Home
590 Longworth Road LONDON ON N6K 4X9

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

NATALIE MORONEY (610), ALI NASSER (523)

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): October 30, 31, 2018 & November 1, 2, 5, 2018

During this inspection the following Critical Incident reports were inspected on:
Log #006559-17 Critical Incident SAC 15192/CIS-2878-000011-17 related to unexpected death.
Log #008932-18 Critical Incident #2878-000014-18 related to missing controlled substances.
Log #010250-18 Critical Incident #2878-000015-18 related to missing controlled substances.
Log #027969-18 Critical Incident #2878-000028-18 related to missing controlled substances.

The following intakes were inspected concurrently while in the home:
Log #024751-18 Complaint inspection IL #59772 related allegations of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Resident Manager of Care, the Assistant Resident Manager of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Clinical Consultant Pharmacist, Pharmacist, Director of Pharmacy Projects, Social Worker, London Regional Police Services, Coroner, Resident Care Coordinator, Environmental Care Manager, Registered Dietician, family members and residents.

The inspector(s) also made observations of resident, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were
reviewed. Inspector(s) observed meals, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices.

The following Inspection Protocols were used during this inspection:
Medication
Nutrition and Hydration

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	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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to protect residents from abuse by anyone and shall ensure that residents were not neglected by the licensee or staff.

MOHLTC received CIS report related to an incident that had occurred to an identified resident that result in a significant change in status and the resident deceased.

Speech Language Pathologist had ordered a specific diet for an identified resident related to a change in condition.

The home's medication reconciliation order form showed the identified resident had a physician order for a specific diet and further review of the order showed only one nurse had processed the order instead of two nurses.

The progress notes showed that a Nutrition Referral was completed by the Registered Dietician (RD).

Review of record documentation did not indicate the identified resident’s diet type, texture, or consistency of fluids.

The RD discontinued all previous diet order and record review showed the diet type was correct per the original orders on the medication reconsolidation order sheet. Two nurses recorded their signatures that the electronic medication administration record (eMar) was documented as checked on the physician order form, however the processing nurse was to initial that the POA was notified and the care plan was to be initialed as being performed but were left not documented as being processed.

The Nurse was called to the identified resident’s room, the identified resident was in

distress, and had deceased.

During an interview the nurse stated that when they called to notify the coroner, they were uncertain if they had told the coroner the incident that had occurred to the identified resident.

The coroner reviewed their documentation with Inspector and stated they were not told about the incident that occurred immediately prior to the specific resident had deceased.

A review of homes' internal investigation records showed that staff had provided the identified resident with the incorrect diet order.

The Administrator acknowledged the medication reconciliation orders for resident was transcribed incorrectly, one nurse only checked and documented for the review of the orders. The Administrator further acknowledged that the plan of care was not updated to reflect diet/texture/fluid type with a change in condition for the identified resident and stated the homes expectation was that plan of care reflected the resident's assessments and care needs, provided clear direction for staff and that the identified resident was provided with correct diet that was safe.

Severity was Actual harm, scope was isolated, but upon reviewing the compliance history of the issue it has been confirmed through the inspection that the non-compliance has been addressed and rectified by the home since the non-compliance occurred.

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 shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written medication management system were developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The home's policy Narcotics and Controlled Substances:
-Discontinued Narcotics (D/C) and controlled substances all D/C, narcotics must remain under double lock and key until disposal, by Manager of Resident Care MRC/designate and pharmacy.
-Wastage of a Narcotic will be witnessed by two registered team members.
-Registered Team member will notify the Manager of Resident Care (MRC) if the narcotic count is inaccurate. Immediate action is required if any discrepancies are noted.

1) The Ministry of Health and Long Term care received CIS report related to missing controlled drug substance's that were unaccounted for at the time of drug destruction for controlled drug substances.
The Pharmacy and the Assistant Resident Manager of Care (ARMC) were completing the drug destruction for controlled substances. The CIS report documentation showed that the home had "completed a thorough investigation and it was determined that a card" of controlled substances were unaccounted for. This was discovered during the medication destruction process with their contracted pharmacy. The discarded medications were inserted in the secured drop box, the medication had been doubled signed at the time of discard by two registered team members in the home.

Review of the internal investigation notes associated to the CIS showed that there was no completed documentation related to the incident and that the home had not immediately completed an internal investigation.

During an interview with a nurse they stated that they had drug destructed the medication card with another registered staff member but was not interviewed by the home related to the missing controlled substances.

During an interview with a nurse they stated that they might have completed the drug destruction for the unaccounted controlled substance but was not interviewed by the home related to the missing controlled substances. The nurse also stated that at times the controlled substance lock box was too full and they had contacted the ARMC #107 as staff could reach in and take cards out of the box.

Police had been notified of the incident by online reporting but had not gone to the home to actively investigate.

Further record review showed that a nurse had received a letter of education related to not properly documenting wastage of a controlled substance by two registered staff members.

There was no documentation provided by the RMC that the day nurse who had not signed for the individually controlled substance had been interviewed and there was no record of documentation to show that the nurse had indeed wasted a controlled substance.

During an interview with the Administrator they said that the information that had been provided was not relevant and was not related to the controlled substance that was unaccounted for. Furthermore the Administrator said that the error should have been reviewed with the day nurse who had not documented the medication on the individual controlled substance sheet and that the home did not conduct and document the immediate investigation related to the incident and was unable to provide records of the immediate investigation documentation.

2) The Ministry of Health and Long Term care received a CIS report related to missing controlled drug substances.

Review of the CIS report showed "after a thorough investigation it was determined that a card of controlled substances were unaccounted for. This was discovered during a medication destruction with the AMRC and the pharmacist. The medication was discarded by two Registered Team Members in a secured drop box. The assistant

manager of resident care and manager of resident care both did a thorough search of all designated medication storage areas and the card of medication was not located".

A nurse stated that at times the controlled drug destruction box had been seen overflowing and it would have been easy to reach in and take the medication out of the box.

Police had been notified of the incident by online reporting completed by the home but had not gone to the home to actively investigate.

The RMC stated that they had two locked controlled substance bins for drug destruction in the home. The pharmacy at the time was Classic Care Pharmacy (CCP) the home had transitioned to Silver Fox Pharmacy. The home had removed both controlled substance bins for drug destruction in the home, and now only had one controlled substance bin for drug destruction in the home. The drug destruction box for controlled substances was kept locked in the RN office and was double locked and bolted securely to the floor related to missing controlled drug substances.

The CIS report showed that the identified resident was being administered a controlled substance for pain control and noticed at the time of removal the patch was missing.

The RMC stated that there was two controlled substances that had gone missing and that one of the two patches had been found.

The Administrator acknowledged that an internal investigation should have occurred immediately after the missing controlled substance could be accounted for and documented and they did not.

The RMC stated that they had not amended the CIS with an update and that one of the two Fentanyl patches were found in an identified residents room. The RMC stated that they followed the licensee policy for destruction of a controlled substance.

The licensee failed to ensure that the written policies and protocols were developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

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 written policies and protocols are developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

Issued on this 12th day of December, 2018

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

Original report signed by the inspector.